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Examining the Critically Reflective Approach and the Use of Self in Practice with Older Adults
Living With Mental Ill-Health

Advanced Practicum Thesis
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by
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Abstract

The following advanced practicum document reviews my social work practice experience on both the In-Patient Psychogeriatric Unit as well as the Out-Patient Geriatric Behaviour Response Team within Grey Bruce Health Services (GBHS) hospital in Owen Sound, Ontario. Through the course of this practicum I was able to engage in various direct practice and assessment opportunities within both a medical and community setting. Through these opportunities I was able to engage in critical reflective practice and examine my use of self within a therapeutic setting with older adults, living with dementia. A comprehensive literature appraisal was conducted in order to demonstrate the rationale and increased need for working with the older adult population. As well, it highlighted the role that critical reflection of self plays within ethical social work practice, and details the positive and challenging nature in engaging in this form of reflective practice.

This document goes on to detail various aspects of my advanced practicum experiences and the opportunities I was afforded at GBHS. During my time with both the in-patient and out-patient teams, I was able to work within a multidisciplinary, medical team setting. This in turn, provided complex and unique lenses in relation to my practice reflections and the various dynamics of power between professional roles as well as with client and their families. Lastly this document reflects on my own personal journey through the course of this advanced practicum and how it in turn has enhanced my personal life, social work practice and clinical assessment skills.

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“And I wish that I could take us back once more. Just to live again the times we had before”.

- *Yesterday's Wine*

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Chapter One: Introduction

Overview

This practicum discussion examines my experience exploring the critical reflective approach and the use of self in direct social work practice with in- and out-patient services for psychogeriatric behavioural support. It provides a comprehensive literature review which explores the topics of critical reflection and the use of self in detail. It describes my practicum environment and my learning goals identified prior to beginning this practicum journey. The fourth chapter examines my use of critical reflection and the use of self in practice through critical analysis. Finally, this document ends with a concluding chapter that highlights the relevance of this practicum to social work practice. This chapter begins by exploring the relevance of this topic in relation to current and future social work practice in Canada, critical social work practice and the use of self, related to my practicum at Grey Bruce Health Services Hospital in Owen Sound. Relevant terms are defined, personal stakes in exploring this topic highlighted, and questions from the onset detailed.

Relevance of Topic

As of July 2015, 16.1% of Canada's entire population is considered to be elderly (Statscan, 2015). By the year 2056, it is predicted that those aged 65 and older will make up approximately 27.2% of Canada's total population (Ministry of Industry, 2011). Of this total population of seniors, more than 12% resided in Ontario in 2006. The Ministry of Senior Affairs (2002) has predicted that this number will double by 2028. A recent study by the Ontario Trillium Foundation found that of the total Ontario senior population, more than 15% reside in a rural community (McDonald, 2011). With an increase in senior representation in Ontario, it stands to reason that various mental health and behavioural issues related to older adults and

aging will also be on the rise. The Canadian Mental Health Association (2010) predicts that between 17% and 40% of older adults will face ill-mental health concerns as they continue to age. The onslaught of geriatric related issues that will be developing as a result of this increase such as health and social issues, make it important for social workers to understand the size and scope of these issues. This is crucial in order to address them properly within a rural mental health setting, where tertiary resources are often limited.

Relevant Definitions

Prior to outlining my advanced practicum and subsequent thesis topic of the critical reflective approach and the use of self with older adults accessing psycho-geriatric behavioural support, some key terms will be defined.

For the purpose of this paper, the term *elderly* or *older adults* refers to people ages sixty-five and older in accordance with Statistics Canada (2015) standards.

When discussing individuals with whom I had the opportunity to clinically work with during my time at Grey Bruce Health Services, I refer to them in a few ways within the following paper. Within much of the social work literature, the term *client* is used to describe individuals who are accessing or receiving services. Given the critical reflective nature of my thesis topic, I use this term interchangeably with the term *participant*, as language is a key piece to minimize the power imbalance within a therapeutic relationship.

At times, as my practicum was completed within a hospital, I also use the term *in-patient* meaning an individual who was admitted to the hospital, or *out-patient* meaning an individual who was affiliated with a hospital supported program, but was living in the community.

The term *psychogeriatric* refers to psychology with a geriatric specific lens, it is in relation to this practice that I was able to engage with both the in-patient and out-patient teams.

Critical Reflection refers to a framework wherein structured functions aim to challenge, disrupt, and alter structural oppression and bring about social change (Trevelyan, Crath & Chambon, 2014; Fook, 2012). Through my practicum I was able to participate in critical reflection with various consultative sources, providing additional lenses for challenging oppression.

Lastly, often in social work the term supervision is used to describe the meeting and discussing of performance or concerns within practice between a supervisor and practicum student. In light of the critical approach and its relation to language and power, this is discussed further within the literature review. I have chosen to use the term *consultation* instead of supervision as it seeks to equalize the power imbalance within the supervisor/worker relationship.

Geriatric Social Work, Critical Reflection and the Use of Self

Social work must explore areas in the future trend of geriatric considerations that are apparent with the increase of this cohort. In Canada, the impending growth of this (elder) cohort will become reliant on social supports and in turn, rely heavily on more institutionalized supports such as community and institutional health care (Conference of Deputy Minister of Health, 1999). As the elderly demographic holds the highest recorded quotients of cognitive impairment and habitual debility (Wister & Wanless, 2007), respective increases in hospital and community-based geriatric mental health supports are warranted.

Of equal importance to the intervention techniques used in geriatric mental health are the capabilities and ethical standings of those who implement them. Social work, like many human service professions, cultivates and evolves various theories, and practice approaches, which seem to permeate practice (e.g. direct practice, policy provision, research). Although there are constantly new and emerging forms of practice that are based in evidence of efficacy and

efficiency, they all must be delivered by the practitioner thus the practitioner becomes as vital a tool as the method of intervention. As such, a critical reflective approach to practice shifts the focus from the intervention framework to an introspective reflection of the practitioner, highlighting that it is the practitioner's own lens, created by personal history, and biases, that can alter the delivery of any modality (Fook, 2012). Being truly reflective of the self, as a practitioner, offers a platform on which all forms of intervention can be built.

The assumptions that surround dementia and the elderly are founded in a greater social ideology of which we are all a part. Often as social workers we are taught and believe that in following our code of ethics that our profession is morally sound. Holstein, Parks, and Waymack (2011) caution that being morally or ethically competent and sensitive is not enough in and of itself, to produce moral realization in society, that society must be open to accepting the true narratives of those within the assumptions. If we fail to account for these areas of conflicting rhetoric through critical reflection, we risk doing greater harm to the marginalized individuals we support. In doing so we do harm to the legitimacy of social work practice and the development of our field, particularly in the area of geriatrics with the current population shift.

Exploring geriatric considerations within the field of social work is and will continue to be a pressing issue for effective service provision as Canada shifts the baby-boomer generation into the elderly demographic. This includes predominantly mental health concerns, predictors, and interventions of mental ill health, as well as stigmatized beliefs about older adults in relation to cognitive and physical ability. Reflexive practice modalities can aid social workers, and social work students in critical analysis of their practice with direction for further development. Going forward as workers it is imperative to be educated in geriatric specific needs in order to adapt current practice modalities and ensure that, as social workers; we continue to provide effective

practice techniques with these considerations in mind. It is also important to be mindful of and constantly challenging our own beliefs and lenses as practitioners in order to challenge ourselves to do no harm to those we serve regardless of the therapeutic model or framework we may employ.

Personal Reasons for Exploring this Topic through Practicum

Although I have not had formal experience within geriatric mental health, especially in a medical setting, I have had several years of experience and education working with the older adult population in a variety of capacities. In addition to my SSW diploma, I have worked for the past four years in concurrence with my BSW degree to obtain a Certificate of Gerontology from Laurentian University. Much of my academic focus has therefore been focussed on geriatric social work. Within practice settings, I have held various positions in the community geared toward providing support to older adults, including roles such as that of companion, advocate, activation aide, and caregiver. In addition to this experience, I have also held various contracts with the Canadian Mental Health Association of Grey and Bruce as an Urgent Response Worker, and a Leisure Links Program Assistant, which have provided me with some level of insight into the field of mental health. Through this practicum experience I was able to bridge the experiences I have had with these various populations and gain new experiences and knowledge that was mutually applicable to geriatrics and in mental health.

In addition to my academic and practice experience, much of my passion for this demographic comes from my personal experience with my grandmother, with whom I have been closely involved from the time of her diagnosis of dementia and mental ill-health, throughout her continuing journey. I have always had a very close relationship with my maternal grandparents and believe that this has also supported my passion and focus for geriatric social work practice.

Having gone through her journey living with dementia alongside her, my first-hand knowledge has hopefully translated to an empathetic response to clients and their families; and will hopefully aid in the development of trust within our relationship, and allow me to support them with this additional level of awareness. Although this passion and my various experiences will serve me well in my MSW Advanced Practicum and future social work practice, I recognize this is an area which requires much critical reflection, especially because of my personal connection to the population and the dementia disease process.

Additional lenses that I must be aware of and through which I view and engage in my practice are influenced by my various aspects of my social locations. These lenses include but are not limited to: being a twenty-seven year old, Caucasian, female, living within the lower middle class, who is obtaining a graduate degree, all within a neo-liberal social context which currently aligns with generalized Canadian values and norms. These lenses mentioned here will be explored in greater depth during the goals and reflection chapters of this document, but bear mentioning here so that any influences of these areas in the writing of this document can be addressed.

In order to fully explore critical reflection and my use of self with older adults, I felt that a practicum was the most appropriate course of action. As mentioned, though I have had some practice experience with older adults and mental health separately, I felt that having the opportunity to explore these two areas together allowed me to expand my breadth of knowledge and experience. In addition to this, as I have spent the last seven years in academia on a full-time basis I was excited to have the opportunity to utilize and expand on my current knowledge base of theory through praxis. Exploring this topic within a practicum setting also aligned with my academic career as mentioned, I had tailored my college diploma, undergraduate, and graduate

degrees, to incorporate the study of geriatrics, specifically in the area of dementia, into my social work education.

Introduction to Grey Bruce Health Services, Unit 4-6, and BSO

My advanced practicum took place at Grey and Bruce Health Services (GBHS) Hospital in Owen Sound, Ontario. More specifically, I was fortunate enough to work with those on the Psychogeriatric in-patient Assessment Unit at the hospital as well as with the Behaviour Supports Ontario – Geriatric Behavioural Response Team for out-patients. Each of these areas are an amalgamation of mental health, addictions, and behavioural support for older adults; the defining difference is that the unit is based within the hospital while the BSO team is based within the community. The main focus of my practice within these respective areas was on case management, counselling, outreach community support, education, and referral. It is within these areas that I hoped to gain a better insight of my role as a practitioner and what my interpretation of these areas holds in terms of my use of self to enrich the process of praxis (Lee, Sammon, & Dumbrill, 2006). Grey Bruce Health Services and the subsequent teams I was able to join while completing my practicum will be discussed in greater detail in subsequent chapters of this paper.

Questions from the Onset

In order to develop my knowledge and awareness critical reflection and the use of self in practice I established the following questions to guide my learning throughout my advanced practicum. These questions were developed from the information gained from my literature review and tailored to engage with the specific environment and individuals I worked with during my time at Grey Bruce Health Services in Owen Sound. The questions are as follows:

1. How my use of is self-implemented within both psycho-geriatric assessments and in clinical out-patient practice? Does this evolve over time, and if so, how so?

2. What critical reflection skills will I use within this practicum to support change and transition within myself, and with other staff, patients and their families?
3. How will I make use of critical reflection used within GBHS? How can this help me explore/challenge the obstacles I have faced within my practice?

The goal of this advanced practicum report is to examine how I was able to meet the learning objectives I had set out throughout the course of my practicum. It begins by providing a thorough examination of the scholarly literature on dementia, critical reflection, and the use of self. It then explores my learning goals and the various ways in which I was able to attain these goals. Lastly, a reflection of my practice during my time at GBHS is discussed culminating in the exploration of the implications of this topic on my future social work practice.

Chapter Two: Literature Review

Overview

This literature review focuses on dementia, the critical approach to reflection, and the use of self. The first section will provide an overview dementia. Next, a critically reflective approach is discussed inclusive of the ways that knowledge, power, language, narrative, discourse, and identity impact practice and use of self. Lastly, the goals, challenges, and ethical considerations of critical practice are reviewed.

Dementia and Behaviours

According to the World Health Organization (2012) dementia is one of the largest public health challenges in the world, so much so that it is seen as a “public health priority”. Dementia is currently defined as “a group of brain disorders that affect multiple cognitive functions, such as memory, language, visuospatial perception, praxis, insight, reasoning, and judgement” (O'Donnell, Molloy, & Rabheru, 2001, p. 15). Currently in Canada, a new case of dementia is diagnosed every five minutes (Wilson, 2014). Various forms of dementia (of which there are over 100) disproportionately affect older adults (Dudgeon, 2010). The most common form of dementia is Alzheimer's disease, and since its discovery in 1907, no cure has been uncovered for this debilitating, degenerative disease (Pianosi, 2008). It is so prevalent that according to Statistics Canada (2014), Alzheimer's disease was among the top ten leading causes of death for Canadians.

In 2011, 747,000 of all Canadians 14.9% of which are seniors over the age of 65, were/are living with some form of dementia (Alzheimer's Society, 2012). According to the World Health Organization (2012), the risk of developing dementia doubles every five years for an individual once they reach 65. Following the projected increase of the overall elderly

population in Canada, the rate of those living with dementia is also expected to increase. By the year 2038, it is estimated that a new case of dementia will be diagnosed every two minutes (Wilson, 2014). If nothing changes by 2031 there will be a projected 1.4 million Canadians living with dementia (Alzheimer's Society, 2012). Although dementia is overrepresented among Canada's elderly, recent studies show that young-onset dementia is becoming a concern (Pot & Petrea, 2013). Though my practicum was focussed on older adults, it bears mentioning that young or early onset dementia is also on the rise. Young-onset dementia usually presents between the ages 40-64, and as of 2010, 14% of all dementia cases in Canada are occurring within this demographic (Shnall, 2015; Dudgeon, 2010). As the study of young-onset dementia is in its infancy, the focus of dementia and dementia care continues to focus on the older adult demographic. Regardless of the age of onset, living with dementia can be very difficult on both the individual living with the disease and those who are providing care. In addition to the myriad of cognitive disorders that can begin to effect brain function there are also often changes in behaviour that occur as a result of the physical restructuring of the brain.

Although some behaviour is more commonly seen with a dementia disease progression such as wandering, some behaviour escalates and at times can generate safety concerns for the individual living with dementia or those around them, or can increase levels of burnout within their caregiver. Habitually, negative behaviours exhibited by those living with dementia were addressed through pharmacological intervention. However, in recent years there has been a shift in practice techniques which highlight the importance of non-pharmacological interventions, such as person-centred therapeutic techniques, as well as music, and art therapies, that can be used in place of or in conjunction with pharmacological interventions that yield a more positive result (Ray & Mittleman, 2015). Ray and Mittleman (2015) posited that the negative behaviours

people with dementia exhibit are a result of unmet needs. Following this line of reasoning, supporting the use of pharmacological interventions alone could increase risk of harm for the individual. Social workers and qualitative research can play an imperative role in identifying what these unmet needs of the individuals are, and work towards a collaborative treatment method. Once identified there is a place for advocacy within the medical system for inclusive methods of care that support the agency of the patient. In addition, conventional treatments that hinder the patients' quality of life can be mitigated and used in tandem with wholistic approaches to preserve autonomy and quality of life during the course of their disease.

As the Canadian population continues to age, and live longer, it stands to reason that the prevalence of dementia and related negative behaviours will also increase (Alzheimer Society, 2010). Currently the causes of dementia are unknown and there is no cure. As such, it is important for people to be aware of dementia as a disease and its growing prevalence within the Canadian landscape. Developing a better understanding of what dementia is, the various types of dementia, and how it can impact the lives of those living with the disease as well as family, friends, and caregivers will be an important consideration for social workers going forward. This is especially true with the projected increase of the older adult population as many of these individuals will be cared for in a community setting; and either the individuals themselves or their caregivers may require clinical support. In accordance with the OCSWSSW Code of Ethics and Standards of Practice (2008) social workers must be able to engage with clients and their concerns in a sensitive, knowledgeable way that is ethical and does no harm to the client. Therefore this topic is timely and appropriate for exploration as the onslaught of geriatric and purposed dementia related issues will continue to increase in both size and scope within the field of social work.

A Critical Reflective Approach to Social Work Practice

The critical reflection approach to social work and the use of self are contemporary topics within the social work field. Critical reflection in social work began predominantly with Donald Schön's (1983) work and has become a significant concept in social work practice. In order to gain a better understanding of the critical approach, critical reflection and the use of self in social work, as well as in preparation for my MSW Advanced Practicum, I have prepared a literature review on these topics. Various texts and databases (based in social work, as well as general areas of study) were utilized for this review. These included searches of the following databases: Ebsco Host, Social Work Abstracts, Academic Search Premiere, Social Service Articles and Google Scholar using keywords such as: use of self, critical theory, critical practice, and critical reflection in practice with older adults. In addition to these searches, I have also drawn from several texts including: *Revisiting the Use of Self: Questioning Professional Identities* (Mandell, 2007), *Practicing Critical Reflection: A Resource Handbook* (Fook & Gardner, 2007), and *Social Work: A Critical Approach to Practice* (Fook, 2012).

The following literature review explores the topic of adopting the *use of self*-construct and a critical reflection approach to social work practice and contexts. The review begins with an overview of the critical reflection approach to practice and its framework focuses on knowledge, power, language, and identity. The review concludes with a discussion on *the use of self-construct* within direct practice, including the types and stages of reflection, the goals of critical practice as well as limitations, ethical considerations, and the use of critical reflection within the older adult population.

Critical Reflection

Critical reflection, reflexivity, and praxis have emerged in contemporary social work literature as an important aspect of engaging in ethically sound practice (Fook, 2012; Fook & Askeland, 2007; Fook & Gardener, 2007; Marlowe et al., 2014; Fisher, 2003; Trevelyan, Crath, & Chambon, 2014; Kondrat, 1999). Although each perspective has historical connotations, the evolution of these practices in a post-modern era has opened up discussion for current and future social work practitioners. Much of the literature surrounding critical reflection fails to concretely identify its meaning and subsequent approach (Fischer, 2003). As a result, the following literature review seeks to provide a comprehensive view of the critical reflection approach, as well as the use of self, in social work practice.

With its critical origins in the study of education, and founded by Argyris and Schon (1974), critical reflection within social work was born out of the lack of cohesion between abstract, theoretical teachings and their practical application within social work practice (Fook, 2012; Fook & Gardner, 2007). Given the contextual nature of reflectivity, critically reflective practice becomes an ongoing process that requires constant revision, reflection and action. Critical reflection involves the practitioner examining themselves and understanding how their personal history (historical, social, political views, and upbringing) influence their beliefs, opinions, and actions when working with a client. From there the practitioner must constantly reflect on their practice and challenge themselves on their actions and beliefs in relation to power, knowledge, language, and identity and how these areas impact the therapeutic relationship with clients. Once these areas have been fully examined it is then up to the practitioner to acknowledge these areas and keep them in check in practice to avoid doing harm to the client. Critically reflective social work practice is becoming an increasingly pivotal focus

within social work education, and is argued to be an essential aspect of ethical social work practice as it forces the practitioner to examine themselves as individuals as opposed to ‘professionals’ within a therapeutic relationship and promotes transparency with the client (Trevelyan, Crath, & Chambon, 2014; Fook, 2013, Mandell, 2007; Fook & Gardner, 2007; Kondrat, 1999). Webb (2000) asserted that without critical thought and critically reflective practice, one cannot engage in “good” social work practice that does not do harm to the client.

Good social work practitioners, as promoted within social work education, are taught to be as objective as possible within clinical settings (Fook & Askeland, 2007). Objectivity refers to the belief that society and social values are independent of individual interpretations and experiences; and instead infer that there is an unbiased reality outside that which each individual lives and perceives (Lee, Sammon, & Dumbrill, 2007). In relation to social work, objectivity is seen as the ability to conduct oneself within a therapeutic relationship without personal views, values, and biases affecting the interactions between practitioner and client which limits transparency within the relationship (Lee, Sammon, & Dumbrill, 2007). The concept of objectivity is prevalent within social work practice literature and it is integral to standards of practice, including the Ontario College of Social Workers and Social Service Worker’s Code of Ethics (2008) which states: “a social worker...shall carry out his or her professional duties and obligations with integrity and objectivity” (p.4). Failing to be objective is often viewed as ‘unprofessional’, and seen as restricting practitioners from exploring personal reactions within their ‘professional’ practice (Fook, 2004). The capacity to be objective requires an understanding of the use of self and ability to self-reflect on one’s own thoughts, actions and feelings; without first identifying and understanding what these are, one is not able to understand how they affect perception and actions. Therefore, the critical approach to practice argues that

practitioners cannot be objective, as they and how they view the world around them are results of their personal historical, social and political experiences.

Fook (2012) noted that the role of the 'professional' social worker is founded in modernist ideals of professionalism, objectivity, and a desired therapeutic hierarchy, which is contradictory to a critical approach to practice. However, there is no delineation between theory and practice; both are heavily intertwined, and it is within this acknowledgement that critical practice is rooted (Fook, 2012). According to Hastings and Rogowski (2014) critical social work seeks to create an anti-oppressive culture, which expels abuse and control over others. Critical social work therefore seeks to acknowledge issues of oppression and promote inclusivity. It seeks to do this by viewing issues through a multifaceted lens that incorporates: race, gender, sexual orientation, ability, knowledge, power, identity, and language, which offers a sharp contrast to objectivity in practice. Fook and Gardner (2007) challenged the fundamental discourses within 'professional' practice, and have developed an inclusive practice theory that also challenged the 'profession' of social work itself.

Poststructuralism, postmodernism, and critical theories, are the overarching theoretical underpinnings for critical practice in social work (Fook, 2012; Fook & Gardner, 2007). Each of these theories directly influences various aspects of a critically reflective approach to practice through challenging the pre-structured power, language, and knowledge bases that are held and considered to be 'acceptable' within society. Poststructuralism challenges the belief that there is an objective way in which the world around us is not only viewed but should function.

Poststructuralism believes that 'normal' behaviour is something that is universally determined by dominant group discourses in society; usually in a way that supports the dominant group and perpetuates inequality among other members (Lee, Sammon, & Dumbrill, 2007). In tandem with

poststructuralism, the postmodernist ideology also believes that there is no objective reality, rather that everything is heavily laden with subjectivity based on various considerations of gender, race, and socioeconomic status; and it is in acknowledging these additional lenses that things such as facts, ethics, and socially ‘appropriate’ behaviours can only be determined at an individual level (Lee, Sammon, & Dumbrill, 2007). Critical theory takes from both of these schools of thought and applies aspects of each with an anti-oppressive focus to highlight and challenge marginalizing behaviours, beliefs, and actions especially to those who are oppressed within society (Lee, Sammon, & Dumbrill, 2007). Fook and colleagues highlighted the importance of reframing four main ideas associated with critical social work, explored in depth below (Fook, 2012; Fook & Gardner, 2007). These are: knowledge, power and its use, language and discourse, and identity; as all are socially constructed concepts with current exclusionary discourses.

The Critical Approach to Knowledge

The hierarchy of knowledge places the highest value on technical or scientific knowledge, and knowledge founded through intellect (Fook & Askeland, 2007). The critical approach to social work asserts that practical, personal, emotional, and relational forms of knowledge are just as valuable as traditionally revered knowledge platforms, and are key considerations for critical practice (Fook & Askeland, 2007; Trevelyan, Crath, & Chambon, 2014; Kondrat, 1999). Within a postmodern framework, many types of thinking can be legitimized (Fook & Gardner 2007). In this view, practical knowledge is valued just as much as traditional knowledge. It takes into consideration the context in which knowledge is generated and interpreted, fully recognizing that all forms of interpretation are imperfect. Post-

modernism and Post-structuralism place a greater emphasis on unearthing ‘how’ and ‘why’ experiences come about, as opposed to simply naming the source (Fook, 2012).

Scholars have noted that critical reflection holds a prominent place in building theory, especially within the power relationships involved in research (researcher and participant), as it does between social workers and the clients they work with (Daley, 2010; Fook & Gardner, 2007). Daley and colleagues have also posited that critical reflection and reflexivity can be pivotal to engaging in, and producing ethically sound research. This is obtained through the acknowledgment of power and structures that permeate the practitioner’s and participants’ experiences, the process of research, and the construction of the knowledge itself (Daley, 2010; D’Cruz, Gillingham, & Melendez, 2007; Fook & Gardner, 2007). Stepney (2005) agreed and claimed that it is on this premise that a shift in research and knowledge creation began. This is the basis for validating the concept of knowledge within critical social work practice.

Critical Perspective and Power

Critical theory provides the basis for much of the examination of power within the critical approach to practice, as it highlights that power is not only personal, but also structural (Fook & Gardner, 2007). Social workers have various attributes which enable them to wield power and promote their ‘professionalism’. Webb (2000) highlighted four of these areas: 1) theoretical knowledge bases including competences and education in a variety of social respected subjects including psychology, sociology, policy, and advocacy; 2) Legal power (usually involved in risk assessment) that can influence rights/abilities being supported or removed from an individual if there is a suspicion of harm to oneself or another; 3) Respect based on their elocution and education as credence is given in society to those who have obtained a standard of education and are able to conduct themselves within various environments that are mutually respected based on

knowledge of language and ability. Lastly, 4) the title of ‘professional’, and the recognition of status and power that comes with this title, in order to legitimize the profession and the role as a social worker. It is within these areas that Webb (2000) argued that social workers host “pre-structured power” (p.3) and subsequently must give great attention to these areas to ensure that abuse of this power can be mediated.

By problematizing the concept of ‘professional’ practitioner knowledge, the pre-structured power imbalance between practitioner and client can be challenged and examined (Fook, 2012). Foucault (1988) cautioned that “every relation is a relation of power linked to knowledge construction...it is neither good nor bad but it is dangerous” (as cited in Miehl & Moffatt, 2000, p.342). It is because of this inherent power imbalance that naturally occurs in a therapeutic relationship, that social workers must constantly be aware of the areas in which they hold power and how they exercise that power. This is particularly true when considering structural power imbalances already in place for clients outside the therapeutic relationship. Social workers have an obligation to examine their practice through critical self-reflection to ensure that they are engaged in ethically sound practice that does not perpetuate an abuse of power over those they serve.

Another construct that must be examined when adopting a critical approach to practice is the popularized notion of ‘empowerment’. Within a modernist context, empowerment is often seen as power at the cost of or over another, which serves to perpetuate what Fook (2012) termed ‘oppositional relationships’. Fook (2012) noted that empowerment is a difficult notion to examine within practice; as individuals can exhibit power and/or powerlessness in various contexts. Contrary to the modernist view of power, which sees power as an object that can be traded, the critical perspective views power as infinite, exercised by different people at different

times and within different contexts (Fook, 2012). Often the goal of empowerment is to ‘elevate’ marginalized individuals to more dominant norms. This not only devalues the experiences of the individuals being ‘empowered’, but as Fook (2012) asserted, it also serves to perpetuate the dominance of the group within the ‘norm’. Many researchers agree with this assertion and seek to challenge the traditional notion of empowerment in an oppositional relationship through avenues such as participatory action research; which allows the participants in the research to also be co-researchers (Creswell, 2014). This shift in engaged knowledge creation exemplifies the position that power is infinite and can be exercised in different ways.

Within the critical approach, power and the notion of empowerment need to be examined as fluid concepts within the lenses of diversity, context, and perspective (Fook, 2012). Framing power solely within social structures often places those without power in a helpless position, leaving them to believe that fighting a structural power is overly difficult (Fook, 2012). As a result, Fook (2012) follows Foucault’s examination of power, and believes it serves as the best example of constructing an inclusive approach. Foucault’s examination consists of three main tenets: 1) power is not a commodity, and therefore cannot be obtained, rather it is exercised; 2) Power is not always empowering, and has the ability to disempower an individual as much as it can be a beneficial support for them; and 3) Power is expressed within micro, casual relationships, and is developed within the same (Healy, 2000). It is in recognising these various areas and opportunities for power that social workers have the responsibility to be aware of and challenge pre-structured power imbalances within society, research, and within their own therapeutic relationships. One way to examine this power is to understand where the concepts for these shifting power dynamics come from, why they are accepted and how they can be

influenced and perpetuated through ideologies, language, discourses, and narratives of both participants and practitioners.

Language, Narrative and Discourse in Critical Practice

Ideology is an important aspect to consider within critical social work, as this theory is framed within the belief that ideas either perpetuate or disrupt social 'norms', especially as they relate to specific groups (Fook, 2012). Ideology is often expressed covertly in language, narrative, and discourse. Viewing ideology through this lens is imperative to critical social work practice, as it not only assesses and identifies areas of oppression, but highlights areas for social action and change especially within various power structures. Much like language, the binary opposition found within ideology of ideas and beliefs seen as either 'right' or 'wrong' is a significant limitation that can disempower those whose ideologies are ascribed as 'wrong'. Instead, Fook (2012) proposes that it is important to problematize those ideologies which are deemed 'right' or 'true' in order to gain a clearer understanding of where the construction of the ideologies comes from. An example of this can be seen when examining issues like dementia within the older adult population. By and large, society believed that dementia is a natural part of aging and older adults often fall into two categories: the 'crazy old woman' or the 'dirty old man' (Pianosi, 2008). If we problematize these ascribed ideologies about older adult mental health and gender roles in late life, we begin to challenge the behaviours and the subtext of these ideologies which are based on ageism and patriarchy. Like knowledge and ideology, language, discourse, and narratives are heavily laden with power. The ways in which knowledge, stories, and beliefs are communicated are just as important as how they are generated and interpreted (Fook, 2012). As such, it is of equal importance that language is critically examined.

“Language is not neutral” (Fook, 2012 p.75) and is often distorted through the view of subjective or dominant discourses, which serves to develop or perpetuate ideologies (Mandell, 2007). The term language refers to word choices, often commonly used in society or a particular setting which shape the way in which individual or subjects are viewed. Poststructuralism highlights the various language choices and, affects how knowledge is perceived and interpreted, which subsequently leads to how dominant discourses arise, as part of power (Fook & Gardner, 2007). The authors note that this is predominantly done through the use of binary opposites in language, wherein one binary is perceived to hold power while the other does not. This is often seen when working with older adults within a medical setting. Patients are often quickly described with specific language choices that can shape the ways in which they are viewed within their environment. For example, if a client is choosing to not take their prescribed medication (which is their right) they are documented as ‘refusing’ or being ‘non-medication compliant’. As I witnessed in my practicum, these choices in language can have a huge impact on how other care providers view the individual, and can begin to form a ‘negative’ picture of this client as someone who is ‘difficult’. When examining the language choices, it is easy to see how the belief that accepting medication is ‘right’ and therefore choosing to decline this intervention is seen as ‘wrong’. Through a post-structural lens, the critical approach examines how language and discourse choices inform where power is exercised (Fook & Gardner, 2007).

Discourse is a preferred term to describe the consideration of the intricacies of language as it relates to social contexts through critical practice (Fook, 2012). Discourse is often seen as the overarching rules, beliefs, structures, and practices that construct language and texts, more than the actual language and texts that are produced (Lessa, 2006). This becomes evident in the exchanges that occur between the person seeking services and the agency or individual that they

seek it from. Discourse allows for a more subjective and complex view of thought processes, beliefs, and narratives than does ideology (Fook, 2012). Fook (2012) asserts that discourse is encompassing of all aspects of a person physically, emotionally, and spiritually as these impact the ways a person communicates. Whereas ideology is often projected and hidden in discourse and is laden with social/political pre-structured power imbalances (Fook, 2012). Foucault proposes that discourses are a way of making meaning of various narratives and ideologies, which are socially constructed and supported by traditional, hierarchical knowledge (Weedon, 2008). An example of this might be seen when working within a multidisciplinary setting such as a hospital when examining the numerous discourses of the various professions. As a social worker within a medically based environment, where objectivity and scientific knowledge are tantamount, having a critical, subjective eye becomes a competing discourse within the environment.

Narratives are closely related to discourses, because they frame individual social experiences and unique world views (Fook, 2012). Kondrat (1999) posits that within the critical reflective approach to practice, it is believed that both the self-narrative of the client and the self-narrative of the practitioner work together to create the context of the therapeutic relationship. It is within this same context that both persons are encouraged to integrate examples of their self-narratives into the relationship. He states the aim is to demonstrate and reflect on ways that these narratives influence the relationship, and how through these, each person has the opportunity to make meaning of the relationship

In light of this, Fook (2012) notes it is in examining the language as well as where the language choices come from, and how they either work to challenge or uphold various social constructs that critical social work practice can take place. This is particularly true for issues

surrounding the marginalized groups that social workers support in practice as these constructs or beliefs are examined on a macro, mezzo, and micro level to gain a better understanding issues of intersectionality that they may be facing (Fook, 2012; Mandell, 2007). Older adults offer a great example of the social constructs that can impact various groups who then face additional issues of intersectionality. Old age is not something that is often valued in the Anglo-Saxon, Western world. Value is often placed on children and youth who are commonly seen as ‘our future’ in society. The ironic truth is that everyone ages. Despite this, youth are socially accepted as vibrant, beautiful, and are celebrated, whereas reaching an ‘old’ age is equated with loss, decay, and inability (Minichiello, Browne, & Kendig, 2000). These labels in turn become attached to the identity of individuals and impact their self-perception, particularly as they interact with the various power-laden structures around them (Fook, 2012).

Critical Approach to Identity

Identity is often ascribed to individuals by others, who are in places of power. The labelling of the identity by others can often disempower those receiving the label as it is forced upon them, which is also described in the literature as “othering” (Fook, 2012). Through the critical perspective however, it is also important to note that apart from being ascribed an identity, individuals also engage in creating their own identities, which are mediated through subjective personal, social, and historical contexts (Fook, 2012; Mandell, 2007).

Understanding the complexity and fluid nature of the self poses important implications for critical social work practice, particularly when examining the identities of social work practitioners (Fook, 2012). The development of identity in social work has been a major challenge and goal of the ‘profession’ and is a main component of contemporary social work education (Miehls & Moffatt, 2000). Without critical reflection, Miehls and Moffatt (2000)

caution that practitioners often attempt to control their anxieties in practice through the veil of their role as ‘the professional’. Smith (1997) argues that when social workers are transparent with their participants that a shift in identity can occur from a ‘professional’ to a ‘person’ which is not only beneficial for the therapeutic relationship, but can also enrich the identity of the practitioner (as cited in Miehl & Moffatt, 2000). Within the frame of social work, this serves to shift from the ‘profession’ of social work to the practice of social work. Social workers often expect their clients to be open and vulnerable within the therapeutic relationship. Examining the self as a social worker allows for a mirroring of behaviour from the practitioner and supports the notion that at the core, social workers are a person before they are a profession. This makes it clear that social workers are not infallible, rather, through recognizing and being transparent about their humanity, their humility, and their emotions they are relatable to their clients, and more authentic to their self-narrative.

With their intentions often rooted in social justice, social workers must be wary of creating identities for clients (e.g. as victim, or person needing empowerment), just because the individual is receiving support from a social worker (Fook & Askeland, 2007). This concern of creating an identity for a client can be mediated through the critical reflective approach to practice by the practitioner challenging themselves, and their beliefs and actions, and reflecting upon pre-existing power structures and power laden discourses, especially within the social work field (Trevelyan, Crath, & Chambon, 2014). Through this practice, social workers actively participate in exploring and challenging pre-conceived notions about their clients that in turn helps to prevent the negative aspects of labelling. This also serves to problematize the positions that social workers fill within current social and political structures and discourses such as policy

advocates, community developers and clinical practitioners (Trevelyan, Crath, & Chambon, 2014).

Post-modernism seeks to break down hierarchical structures of ‘professional’ and ‘client’ calling into question the actions of the practitioner and giving credence to the client’s perception (Fook, 2012, Hastings & Rogowski, 2015). An interesting conflict for practitioners’ identity is found within the notion of being a ‘prosumer’ (Grant, 2007). Grant (2007) refers to social workers who have also been service users as ‘prosumers’ and reflects that prosumers must diligently engage in reflective work to refrain from translating personal experiences as models for participants and reinforcing negative social norms. Fook (2012) highlights that social work practitioners often covet the identity of ‘professional’ and reject to some degree, the identity of being a ‘service user’. This is another example of the importance of exploring the use of self and problematizing the title of social worker within practice.

The Use of Self

The use of self is a topical subject within social work literature as a whole, with substantial roots in supervision literature focussing on transference, countertransference, and self-awareness (Chapman, et al., 2003; Knox & Hill, 2003). Mandell (2007) argues that examining and understanding the use of self within social work should be considered as an intrinsically essential component of practice, because it begins to reframe the focus from an individualistic stance to a more relational one. Conventional ideology surrounding the use of self often falls into the binary opposition of ‘transference’ or ‘countertransference’, however, these concepts fail to address the other subjective pillars of critical practice – knowledge, power, and language (Mandell, 2007). Examining the use of self is an intrinsic part of critical practice, because, as Reupert (2006) indicates, the influence and presence of the self is inevitable and

permeates all aspects of practice (Trevelyan, Crath, & Chambon, 2014). Reupert (2006) and Ganzer (2007) argue that the self is the tool through which therapeutic change is facilitated.

The use of self takes the facet of critical reflection one step further, by examining the role that the subjectivity of the practitioner plays within their practice, and how this subjective nature, which is developed through our experiences with others and our world, is intrinsically related to our experiences and perceptions of power (Trevelyan, Crath, & Chambon, 2014). In order to understand ourselves as practitioners, the self has to be seen as a conduit of socially, politically and historically influenced power and knowledge and cannot be segregated from these concepts (Deleuze & Joughin, 1997).

According to Radford and Huspek (1997), when the social worker engages in practice with a participant, that social worker is working within the situation and is longer at a distance. The notion that practitioners can remain neutral and objective within 'professional' practice is misleading and skews the relationships with colleagues and participants (Miehls & Moffatt, 2000). The notion of self is not and cannot be solitary, but is formed and explored through various intersubjective relationships (Deleuze & Joughin, 1997). Miehls and Moffatt (2000) emphasize that social workers are not outside of 'the other', as many practitioners also face discrimination based on their social locations. An example can be seen in the intersectionality of many social workers who may also be male, minorities either culturally or racially, or have had to or are seeking, services for their own personal needs. There is the possibility that these individuals may feel a part of 'the other' especially in a profession that, both historically and currently, is predominantly made up of Caucasian, Anglo-Saxon heterosexual, females.

Kondrat (1999) provides the example of evaluating the self as if in a mirror, not to create an objective view, but to know oneself within the subjective context of the reflection. This is

often done through consultation, gathering feedback from colleagues, clients, or through reviewing audio or video tapes of recorded sessions (Mandell, 2007). Supervision, among other components of critical reflection, is an invaluable aspect of examining the use of self (Kondrat, 1999). Adamowich et al. (2014) note that social workers themselves often face colonization through their education and training as their ‘wholistic selves’ are often negated in the development of the ‘professional self’. It is proposed that through critically reflective supervision and peer mentorship, the use of self that can be addressed in a more wholistic view (Adamowich et al., 2014). Yorke, Grant, & Csiernik (2016) contended that supervision is the only way to truly examine the self, the aim of which is to become aware and in tune with the self, in all of its subjectivity, in an effort to understand how this lens affects the self and its interactions with others.

The modalities a practitioner uses will have their basis in the knowledge ascertained through formal education and training, but the interpretation of this information and the execution of a modality within practice are filtered through the individual, their social location(s) and historical context (Reupert, 2006). Traditional education and personal experience equally influence delivery and shape the facilitation of practice (England, 1986 as cited in Reupert, 2006). Technique alone does not provide clients with the ability to “heal”. It is technique, personality, and knowledge through the conduit of the subjective self which is most authentic, and therefore as Dewane (2005) noted, provides the best chance for a transformative therapeutic relationship. Dewane (2005) emphasized the importance of integrating personality into practice, through various avenues including touch, humour, and use of belief system. Each of these avenues should only be implemented if they are utilized in an ethical and responsible way, which

is relevant to the context, and would do no harm to the client. These tools should never be used for the practitioner's needs or gains.

Types of Reflection

There are many types of reflection that social workers often practice. As various authors have mentioned, 'reflection' is often an ambiguous term (Fisher, 2003). In response to this, Habermas (1974) historically noted three types of reflection that are still relevant to the exploration of reflection today (as cited in VanMannen, 1977). The first is technical reflection. Technical reflection attempts to examine the efficacy and efficiency of a process in order to arrive at a desired conclusion (Fisher, 2003). It is most akin to an objective stance of reflection. Traditionally this has been the preferred level of reflection used by many within therapeutic relationships; and is often cultivated within human service organizations through supervision. This level of reflection fails to engage the subjective nature of the individual engaging in practice and how their subjectivity influences the outcome. The next form of reflection is practical reflection, which is focussed on examining the desired outcomes and identifying any assumptions that are founded, while acknowledging that the meanings of both the goals and assumptions are mediated through language (Fisher, 2003). This form of reflection embodies some aspects of a poststructuralist review of language and a postmodernist view of how knowledge is created and interpreted. Lastly, critical reflection can be identified as the examination of issues of equality, power, and justice, through the exploration of personal implications within social, political, and historical contexts (O'Hara, Weber, & Levine, 2010; Van Manen, 1977). It is in examining the various types of reflection that it becomes clear why critical reflection in social work is necessary. In order to practice in an ethically sound manner, the social worker must explore the personal contexts that influence their practice beyond

language, goals, and assumptions alone. This form of critical reflection serves as a conduit to improved practice within the field as the social worker's critical awareness grows.

Stages of Critical Awareness

Not only are critical reflection and the *use of self*-concept vital to ethical practice, they also serve to support the practitioner in understanding how knowledge, power, discourse, social, and historical context affect their mental, emotional, and physical practice (Marlowe et al, 2014). Marlowe et al. (2014) and Kondrat (1999) argue that there are four main points along the continuum of critical awareness in which practitioners can progress to develop and inform practice. These stages include:

Pre-reflection: During this stage there is not yet any reflection on the part of the practitioner – assumptions, beliefs, and values held have yet to be examined (Marlowe et al., 2014; Kondrat, 1999).

Reflection: At this stage, the practitioner has begun to examine actions, thoughts, beliefs, and assumptions. The practitioner is able to review these in relation to past practice situations, and begin to decipher where some of these may stem from (Kondrat, 1999). Marlowe et al. (2014) point out that although reflection begins to shift knowledge from a purely theoretical perspective to a more practical realm; it can also be useful in the development of what Fook and Gardner (2013) call a “transformative agenda”. As such, reflectivity is seen more as a process moving towards reflexive practice (Fook, 2012).

Reflexivity: This stage takes reflection to the next level. Here, the practitioner is mindful not only of the aforementioned areas found within reflection, but is also aware of discourse/language, power dynamics, and how these are all filtered through the ‘self’ within and outside of practice settings (Marlowe et al., 2014). In addition to the added

levels of contextual depth, reflexivity is also distinguished by its timing (Trevelyan, Crath, & Chambon, 2014). Whereas reflection is focussed on examining an experience that has already happened, reflexivity is focused on examining these considerations in the midst of practice (Trevelyan, Crath, & Chambon, 2014; Fook, 2012; Lam, Wong, & Leung, 2007; Yorke, Grant, & Csiernik, 2016). Fook and Gardner (2007) posit that reflexivity moves beyond examination of the self within context, but also informs the creation of knowledge.

Praxis: Lastly, considered the ideal state in critical awareness development, is praxis (Marlowe et al., 2014). It is within this stage that the practitioner is able to take what has been ascertained through reflection and reflexive practice and translate it into improved practice (Marlowe et al., 2014). Praxis, is the next step to ‘in action’ reflexivity where, beyond noticing and evaluating the various discussed dynamics during practice, the practitioner begins to integrate changes at the micro and/or macro levels in response to the contextual considerations in front of them (Marlowe, et al, 2014). The authors agreed with Freire (2005) in the belief that praxis brings about a more wholistic form of knowledge, which highlights personal connection to self, society, and others.

Older Adults and the Critical Approach to Practice

Although the critical approach to social work is not new, very little research (technical or critical) has been conducted with the focus of working this way with older adults, highlighting a current gap in research of this topic, and within this population. This is intriguing, as critical gerontology also closely aligns with the critical approach to social work (Hastings & Rogowski, 2014). Within their study, Hastings and Rogowski (2014) spent considerable time exploring the social and political constructs surrounding the negative notions of age, the process of aging, and

the various ways in which neo-liberalism influences these assumptions. Through a neo-liberal and ageist discourse, older adults are often portrayed as a collective, and as the “other” within the media (Hastings & Rogowski, 2014). This forces the members of this population to be stripped of other aspects of their ‘selves’ such as gender, religion, culture etc., and perpetuates narrow, dichotomous thinking (eg. old vs young) (Hastings & Rogowski, 2014). The social constructions and assumptions of aging held at the macro level permeate and are reinforced by institutional settings (such as hospitals and long term care homes) and extended to the micro level, through interpersonal relationships (Hastings & Rogowski, 2014). For example, should an older adult present to the hospital with responsive behaviours or confusion, often it is attributed to dementia and age rather than other potential social, emotional, or medical causes. It is for these reasons and various social and political constructions such as ageist ideals that are perpetrated through policy and practice, that further exploration of critical reflection, reflexivity, and use of self would be justified to promote safe and ethical practice with this expanding population.

Goals of Critical Practice

Fook and colleagues assert that the process of critical reflection is not just about engaging in effective practice, but to also develop a practice culture that promotes discussion and exploration, while examining and challenging assumptions, in an effort to promote (or generate or foster etc) social change (Fook & Askeland, 2007; Fook & Gardner, 2007; Fook, 2012). The aim of this is to create an anti-oppressive culture which expels abuse and control over others through examining the use of self and the perception of others (Fisher, 2003).

Overall, critical thought challenges many of the current bureaucratic cultural norms of human service organizations, and challenges those within these settings to critique the various ideologies that they are working within and often perpetuate (Fisher, 2003). The goal of

examining the use of self is for practitioners to gain an understanding of how the person they are, and the experiences they have had, influence how they interact with and react to others. Through this examination of self, practitioners can create various meanings of these experiences within practice settings (Kondrat, 1999) and incorporate these into reflexive practice with their clients.

Apart from this overarching goal, there are other objectives to consider which connect with practitioners on an individual practice level. One such goal is to allow the practitioner to recognise and examine various social, cultural, and structural assumptions they hold, especially in relation to power, in order to foster transformative practice (Fook & Askeland, 2007). Many of these cultural norms are exhibited in clinical social work practice. Fook and Askeland (2007) highlight the example that within a clinical relationship the practitioner will often ask and expect the participant to disclose personal information. This is not an expectation that the practitioner may hold for their colleagues or friends. It is in questioning this cultural practice that the social worker can begin to examine their “pre-structured power” (Webb, 2000).

In addition to this, critical practice and the use of self seek to support the practitioner, and by extension the participant(s) through gaining an understanding of various emotional, mental, and physical reactions experienced within direct social work practice (Marlowe et al., 2014). Bercei and Napoli (2006) posit that it is in being mindful that these reactions are not a permanent part of the self, and responding to them, creates a healthier space for the practitioner and could reduce burnout through critical reflexivity, and praxis (as cited in Marlowe et al., 2014; Fook & Askeland, 2007).

Challenges within Critical Practice

The primary challenge to engaging in critically reflective practice is often the practitioner themselves, who may not want to, or have never engaged in self-examination (Marlowe et al.,

2014). As the individual becomes more familiar with posing critical questions to themselves within the various aforementioned contexts of knowledge, power, language, ideology, and the relationships within which these constructs are played out; practitioners are able to engage in critical reflection in an effective manner. Being conscious of self in practice also helps to develop the related skills to process difficult situations faced in the field (Marlowe et al., 2014).

Brookfield (1995) cautions social workers that there are various types of sequential cultures that can have a negative impact on critical reflection. These cultures are: silence, individualism, and secrecy. The culture of silence in social work offers no opportunity to speak openly about or to make meaning of the various mentally and emotionally significant experiences the individual has had within practice. As a result of this a culture of individualism develops, making it difficult for collaborative efforts to immerge among practitioners and often fosters the belief that individuals must have their own answers; this leads to the culture of secrecy. Within this culture there is an intense sense of anxiety, fear, and embarrassment surrounding the self-disclosure, of mistakes or growth opportunities for fear of reprimand. Within these contexts the format of asking critical reflection questions can cause the practitioner to feel vulnerable, especially if critically debriefing with peers (Fook & Askeland, 2007). This is especially true as practitioners do not want to openly discuss errors in practice or judgment in their work, thus perpetuating cultures of silence, individualism, and secrecy. However, the authors also note that without asking reflective questions, the complex situations that social workers often face would be dealt with by organizational based policies and procedures alone (Fook & Askeland, 2007).

Given the paradoxical nature of critical reflection, it can create a sense of uncertainty for practitioners who are challenged to problematize their own social work practices (Trevelyan,

Crath, & Chambon, 2014) and long-held biases. This is experienced as social workers often value things like anti-oppressive practice, social justice, and empowerment of clients. To examine their own practice critically, and see areas of bias, oppression or missed opportunities to promote social justice can be difficult to understand, and cause social workers to question their role and even their profession (Trevelyan, Crath, & Chambon, 2014; Fook, 2012). Dewane (2005) posits that ‘therapeutic neutrality’ (p.551) is a myth for social work practice, and that attempting to engage in objective practice can do harm to the participant. Rossiter (2006) goes even further by suggesting that attempting to formulate an objective understanding of the ‘other’ actually does “violence” to the participant.

Failing to problematize social work practice creates an unattainable culture of objective assessment, silence, and individualism, wherein the dichotomy of “correct” or “incorrect” practice is perpetuated, creating anxiety for the practitioner to be “wrong”. This anxiety in turn, is notably the most common barrier to reflection (Ruch, 2002; Fook & Gardner, 2007).

Interestingly, Corey (2012) highlights that anxiety related to these concerns should be used as a catalyst to engage in exploring one’s internal dialogue, through which self-defeating attitudes and behaviours can be challenged. Miehl and Moffatt (2000) argue that it is in this anxiety that practitioners are best able to relate to the ‘other’ and develop their identity as a practitioner through various imaginative possibilities. Fook (2012) concurs and asserted that the role of the ‘professional’ social worker has been founded in modernist ideals of coveting the assumed power and status that comes with a ‘professional’ title, and is contradictory to a critical approach. It is for this reason Trevelyan, Crath, and Chambon (2014) suggested that feelings of uncertainty and anxiety are hailed as necessary experiences for critical practitioners to engage in truly ethical practice.

Critical reflection calls for consultation to support the practitioner on their journey and to normalize feelings of anxiety and concern (Ganzer, 2007). Consultation within the critical approach helps transform practice, to encompass more empowering, ethical, and effective experiences for both the practitioner and the participants. This is done by allowing the practitioner a safe space to debrief events surrounding practice (Marlowe et al., 2014).

Ethical Considerations in Practicing Critical Reflection and Examining the Use of Self

Much of the contemporary literature on critical reflection and the use of self, offers considerations which question social work as a ‘profession’ and speak to how engaging in critical reflection and exploring the use of self in practice promoted ethical responsibility among practitioners (Rossiter, 2006; Adamowich, Kumsa, Rego, Stoddart, & Vito, 2014; Gray & Gibbons, 2007; Gergen, 2001). According to the Australian Association of Social Workers’ Code of Ethics (2010) there are four main causes for ethical dilemmas. These include, but are not limited to: a) interpersonal conflict of interests, b) conflict between the practitioner and their social environment; wherein one’s professional values are at odds with organizational or societal values, c) when client needs are unmet by available resources, and d) when demands for efficiency and results are in conflict with the practitioner’s “ethical responsibilities”. These same responsibilities are reflected in Ontario’s Social Work standards.

In Ontario, social workers are mandated to follow the Code of Ethics and Standards of Practice as determined by the Ontario College of Social Workers and Social Service Workers (OCSWSSW) (2008). This is in accordance with the *Social Work and Social Service Work Act* (Ministry of Community and Social Services, 1998). Gergen (2001) referred to professional standards and ethical codes set out by professions or organizations as “content ethics” (p.8). Although content ethics are generally reviewed as a positive measure, Gergen (2001) noted that

their main function is to offer security to ‘socially accepted norms’ and to police an individual or group’s actions. It is in light of this that ethics and standards of practice are not easily discussed or challenged (Gergen, 2001). Language such as “reflexivity, critique, and doubt” (p.9) are often seen as oppositional to content ethics, however this shift in language and lens offers an opportunity for wholistic meaning making on ethical issues (Gergen, 2001). Gray and Gibbons (2007) caution practitioners that although these guidelines are available to support practitioners in making ethically sound decisions, they do not ensure that ethical social work practices are taking place.

In addition to content ethics, the field of social work is also host to a variety of approaches, theories, and models that can create ethical issues. According to Rossiter (2006), it is the ‘professional identity’ cultivated by the social worker and supported through objective knowledge of these modalities that positions practitioners at risk of “doing violence” to the ethical relationship of practitioner and participant (p.140). Grey and Gibbons (2007) agreed with Rossiter and noted that ethical dilemmas are often multifaceted, as are the resulting responses to them. Despite content ethics, organizational policy, and various scopes of practice supported by the literature, ethical decisions are fraught with subjectivity based on circumstances, the individuals involved, and the relationships that also permeate these considerations (Gray & Gibbons, 2007). In fact, Gray and colleagues assert that social workers have an “ethical responsibility” (p.224) to go beyond how the practitioner alone views a dilemma, and must also include their values, beliefs and the participant’s view, their view of self, their social locations, and their environment (Gray & Gibbons, 2007).

To corroborate this point, a recent qualitative study conducted by Adamowich et al. (2014) explored the use of self among critically reflective social work practitioners. The authors

found that most social workers were experiencing ethical dilemmas within their role as a practitioners; torn between their responsibilities to challenge oppressive power, while remaining unaware of their own power. As a result, the social workers involved in the study found that critical reflective practices were effective approaches to addressing their power within direct practice and within the broader social constructs, allowing them to respond to this ethical dilemma in a conscious and responsible manner (Adamowich et al., 2014). It is in light of this that a critically reflective approach to practice is ethically justified.

When exploring approaches to and decisions about ethical dilemmas, Gray and Gibbons (2007) cautioned that it is critical reflection in conjunction with the use of self that spontaneous practice can be seen as ethically sound. Dreyfus and Dreyfus (1986) caution practitioners that without approaching ethical dilemmas with these considerations, social workers risk developing a disconnected, rational, and wary approach to resolutions. Additionally, it fails to allow practitioners to explore their values and develop imaginative resolutions and cultivate their intuition of ethical dilemmas and instead leaves practitioners needing excessive structure in order to work effectively (Gray & Gibbons, 2007).

Without discounting rational decisions, some authors believe that to practice ethically, social workers must be able to engage in “virtue ethics” (p.235), which are ethics that draw upon experience, intuition, and direct practice examples (Dreyfus & Dreyfus, 1986; Grey & Gibbons, 2007). Virtue ethics are an alternative to content ethics as they place a critical focus on the practitioner and their use of self (Gray & Gibbons, 2007). Through the use of virtue ethics, practitioners become what McBeath and Webb (2002) refer to as a “hermeneutic social worker” (p.1016). Here, the practitioner works within a critical lens to approach the dilemma in a way that is ethically responsive of the self and the other. It is using virtue ethics to evaluate ethical

dilemmas and content ethics that practitioners can be 'ethically responsible' in therapeutic relationships as well as in challenging dominate oppressive powers. (Grey & Gibbons, 2007).

Summary

There has been an increase of interest in recent social work literature exploring the role of critically reflective practice as well as the use of self. Critical reflection, reflexivity, and praxis have immerged as important topics in contemporary social work literature. Although each discourse has historical connotations, the evolution of these practices in a post-modern era has opened discussion for current and future social work practitioners. Much of the published works examining critical reflection and the use of self are centered on social work education studies, direct practice theory, and the ethical considerations of these approaches. Through this literature review I have established that the flexibility of these approaches can be used with various populations in a variety of environments, though only one study with this lens was found to be working with the older adult population. Webb (2000) asserted that without critical thought and critically reflective practice, one cannot engage in "good" social work practice. In light of this, the following Advanced Practicum Thesis subject of exploring critical reflection and the use of self in social work practice with older adults, in my opinion, is appropriate for exploration and reflection.

Chapter Three: Learning Goals

Overview

This chapter details the purpose of my practicum as well as my agreement with Grey Bruce Health Services of Owen Sound. It provides a description of the hospital in general and offers a description of both the in-patient Psychogeriatric Unit and the Behaviour Supports Ontario – Geriatric Behaviour Response Team where I was able to work with older adults receiving out-patient services. The chapter goes on to expand upon the role of my supervisor. It will explore my learning goals of working within a multidisciplinary team, implementing the critical reflective approach and exploring the use of self in practice. The chapter closes with a discussion centred on my goals to develop effective case management skills and to gain a better understanding of clinical consultation with a critically reflective lens.

Purpose of the Practicum

My Advanced Practicum at GBHS included both clinical social work practices within a hospital setting, as well as practice within the community. Through this practicum experience, I hope to be able to enhance the clinical, critically reflective, and reflexive skills I have cultivated through my field experience to date, including my Social Service Worker diploma, and my Bachelor of Social Work degree. My main objective within this practicum was to critically examine my use of self and my approach to practice, in order to develop awareness of myself as a practitioner and my interactions with various individuals, while exploring how these same aspects shape my therapeutic relationships with clients.

It was hoped that this practicum could provide me with opportunities to strengthen my intervention skills, and to make use of them in an ethically sound way. Through clinical consultation with my supervisor at GBHS, and through shadowing various social workers on the

BSO team, it was hoped that I would be able to gain valuable feedback and insight about my clinical practice skills. This was not only advantageous in the completion of my practicum and subsequent thesis, but it would also afford me the opportunity to engage in critical discussions that offer alternative perspectives outside of these environments. This would enhance my own reflection on practice and the use of self.

Agreements with the Organization

A practicum contract was established between GBHS, Laurentian University and myself, agreeing to the completion of 450 placement hours between the months of November (2016) and March (2017). This time line was established as none of the geriatric social workers were full-time and I therefore had to obtain my hours on a part time schedule. In general, I attended practicum between three and four days per week. GBHS accepted my application for an MSW placement, and prior to beginning my practicum I had to complete their extensive orientation and privacy package. As well, I had completed all criminal record, vulnerable sector screenings and medical test requirements to work with medically vulnerable people.

Description of Advanced Practicum Environments and Populations Served

I completed my Advanced Practicum on the Psycho-Geriatric Assessment Unit at the Grey Bruce Health Services hospital (GBHS), located in Owen Sound, Ontario. The GBHS hospital is the largest of six sister hospitals within Grey and Bruce counties, and is the only hospital in the region that offers Psycho-Geriatric support and assessment (GBHS, 2016). In addition to in-patient care, the Psycho-Geriatric Unit also hosts a Behavioural Supports Ontario (BSO) team which is an out-patient service team that conducts community visits in Owen Sound and the surrounding communities of Grey and Bruce Counties (GBHS, 2016). I had the opportunity to complete my practicum on both units.

Within the Psycho-Geriatric Assessment Unit at GBHS, patients are assessed on this sixteen-bed unit and provided with both medical and non-medical interventions to assist in managing problematic responsive behaviours (GBHS, 2016). Patients receive assessments in a variety of areas including but not limited to: pharmacology, capacity, physiotherapy, occupational therapy, dietary needs, and social work. As individuals age, their body breaks down medication differently, for those living with dementia, some medications can become ‘activating’ meaning they result in behaviours, if they are not able to be broken-down appropriately (O’Donnell, Molloy, & Rabheru, 2001). In contrast, if an individual’s behaviours have become unmanageable with non-pharmacological interventions, then an approach that includes medication may be necessary. Each patient receives a medication profile review during their assessment in order to address these issues. In terms of capacity, a large part of the assessment on the unit is to determine if the patient is still cognitively able to make their own financial and care decisions. This was often assessed by the physician on the unit in conjunction with the occupational therapist. These assessments will be discussed in greater detail below, as they relate to the work I did as a part of a multidisciplinary team.

The target stay for assessment is approximately two weeks, however the length of stay on the in-patient unit can depend on a variety of factors including: admitting behaviours, destination upon discharge, as well as available community support. At times, individuals were admitted to the unit in order to provide their caretakers respite prior to transition into a more supported environment, this too can have an impact on their length of stay. For example, if an individual is coming from a long-term care home and is being assessed they can remain in hospital for sixty days before they lose their bed within the long-term care facility. In addition to the assessment that occurs on the unit, there is a detailed discharge process for patients when the

assessment has been completed. Discharge mapping aids in supporting older adults as they transition out of in-patient care to home, or into a long-term care setting. The BSO team is part of an aftercare program for older adults who are living with reactive behaviours in the community (BSO, 2016). Older adults access these services for a variety of reasons, such as mental health, substance abuse, dementia, and neurological behaviours (BSO, 2016).

Both GBHS and the BSO team work to support older adult clients exhibiting problematic behaviours and mental ill-health (including dementia). Within these programs, older adults are considered to be at least 65 years of age, and must be exhibiting mental ill-health, problematic behaviours, have a diagnosis of dementia, or have substance abuse issues. Referrals for assessment by GBHS must be made through a physician; to access the BSO program, referrals can be made through family members, doctors or community partners who provide care. In addition to the older adults supported by both GBHS and the BSO teams, family members are also offered support as they provide support to their loved ones (BSO, 2016; GBHS, 2016). As a result, although the main population that the GBHS and BSO teams serve is composed of older adults, these programs also offer support to family members and various community agencies, which means that they provide support to a variety of ages, genders, cultures, and religions, all who have varying degrees of mental wellness and ability.

Description and Roles of Supervisors

During the course of my practicum, I received the bulk of my consultation from my on-site supervisor an MSW, who is the social worker on the Psycho-Geriatric Assessment Unit at GBHS. The social worker's role on the unit is to assess the client's social positions and obtain a history of the patient's personal/family history including marriage, children as well as any past psychiatric history of ill-mental health, dementia, and recent losses. In addition to this, the social

assessment explores educational/employment background, as this can also help to provide insight into an individual's behaviour and to highlight the unmet need they may be experiencing. For example, an individual on the unit was fixated on rousing fellow patients throughout the night. Upon speaking to this patient's family it was discovered that this patient's past profession was as a nurse who often worked nights. It was upon learning this that physiotherapy and occupational therapy programming were able to be tailored to meet the need demonstrated by this behaviour. Offering this patient to speak with fellow nursing staff about mutually related topics, and providing the patient with her own binder to complete her patient charting were just a few ways that staff on the unit was able to meet some of this patient's needs. This aided in curbing the behaviour that was a safety risk for the patient, especially on a unit of other confused patients who could see this behaviour as threatening. The social worker on the unit ascertains the patient's income sources, and will often speak with the patient, or if their cognition is too severely impaired, speak with family to gain a baseline for the client's personality/habits/hobbies prior to hospitalization. Gathering this collateral information helps to identify changes in personality that can help support staff interventions or diagnoses that is specifically tailored to the patient.

In addition to this social assessment, she is also responsible for submitting Public Guardian and Trustee documentation. As per the Mental Health Act (1990), every person admitted to a psychiatric assessment unit must also undergo a financial capacity assessment. On the unit I where I completed my practicum, this was completed by the physician in conjunction with an occupational therapist. This assessment examines if a person is still legally responsible/able to manage their own finances and property. If a person is found to be "incapable" of this responsibility, then a Power of Attorney for Property is enacted (Mental

Health Act, 1990). This allows for an appointed substitute decision maker to assume responsibility over the assessed individual's finances and property. In the event that an individual does not have a Power of Attorney assigned prior to their change in capability, then the facility is legally obligated to submit a referral form to the Public Guardian and Trustee (PGT) (Mental Health Act, 1990). PGT will then assume the responsibility of the individual's finances, until and if a successful application is made to replace the PGT, under sec 17 of the Substitute Decisions Act, 1992.

As the social worker completing the assessment, she is also responsible for organizing and facilitating family conferences on the Psychogeriatric Unit. Once an assessment has been completed on an individual, the multi-disciplinary team calls the family/involved community supports to a conference where the results of the person's assessment are discussed. The key aspects that are reported on include: the patient's diagnosis and often prognosis, any behaviours exhibited on the unit, as well as any medication changes and the discharge plan for the patient. It is here that she would also explore any community resources that the family or the patient may need (e.g. Alzheimer's Society) and complete appropriate referrals.

In addition to my work on the in-patient assessment unit, I was also fortunate to work with a social worker with the Geriatric Behaviour Response Team (BSO) with out-patient mental health services. Like the in-patient social worker, the BSO social worker was also responsible for conducting social assessments with clients however her assessments were often conducted with a stronger focus on behaviour and non-verbal communication. For BSO services the clinician (in this case the social worker) is also accountable for conducting an assessment on the client's behaviours and functional abilities including cognitive and mood testing. The clinician is also responsible for obtaining collateral information about the client's social history from relevant

staff, caregivers, and/or family members. As many of the clients that are referred to the Geriatric Behaviour Response Team for exhibiting behaviours are also living with dementia, it is important for the clinician to understand who the person was prior to their behaviours and diagnosis in order to develop a therapeutic relationship and care plan that enmeshes who they were in the past, and where they are in their cognitive function and how these two relate, while still meeting client and family goals. Once assessments are complete, and an individual care plan is in place, the social worker is responsible for continued follow up visits with the client until the goals are met and the client can be discharged from services.

Unlike other members of the team who share a caseload, the social worker carries her own. Although she performs tasks similar to other members of the team, such as conferencing clients, service initiation, and discharge planning, she also engages in therapeutic work with clients. Other members of the BSO team, all of whom have a nursing background, are able to make internal referrals to the social worker to work with clients. Her work is generally done in conjunction with medication and spans a variety of theoretical social work approaches depending on client's needs. The out-patient social worker's background is in critical social work practice and she operates within this framework. This was important to my learning process as I will review throughout my discussion of my own learning outcomes.

Consultation

Often in social work the term supervision is used to describe the meeting and discussing of performance or concerns within practice between a supervisor and practicum student. In light of the critical approach and its relation to language and power, I have chosen to use the term *consultation* instead of supervision as it seeks to equalize the power imbalance within the supervisor/worker relationship. Throughout the course of my practicum I was able to engage in

consultation with a variety of social workers, however, the bulk of my consultation was with my primary supervisor. Engaging in consultation with her over the course of my practicum provided me with feedback on my practice skills, and also aided in my own reflective practice. In addition to my primary supervisor, I sought consultation from the out-patient social worker during my time with the BSO-Geriatric Behaviour Response Team. On the BSO team, there is another social worker who works with the Alzheimer's society, with whom I was also able to engage in valuable dialogue and consultation. Although the in-patient social worker assumed the role of my primary supervisor, I was able to consult with all three of my fellow social workers during my practicum. I believe this provided various lenses to my practice and truly enriched my reflective process, as well as my social work practice. My supervisor and I engaged in regularly scheduled supervisory meetings every 2-3 weeks. I was able to consult with the out-patient social workers outside of these scheduled meetings occasionally.

Outside of my practicum, I was able to engage in informal consultation discussions with fellow MSW candidates who are also completing their practicum. Although our discussions were loosely based on the work of Fook and Gardner (2007), much of the discussions were organically driven to explore areas within our practice in a reflective and critical manner. Through this process we were able to explore/ensure ethical delivery of services to clients and to discover the assumptions underlying our clinical actions and interpretations.

Practicum Learning Goals

As noted earlier, I have spent time working with older adults and some time working within the mental health field, but prior to this practicum I have never had the opportunity to combine these two areas. Through my Advanced Practicum, I was able to cultivate and enhance my skill

set and awareness as a practitioner within the geriatric mental health field which was driven by my learning goals. My learning goals consisted of the following:

1. To work as part of a multidisciplinary team within a medical setting to gain perspective and experience of the pre-structured power imbalances.
2. To include the critical approach to practice and explore the use of self to gain a better understanding of its relevance and importance within the social work field, and my practicum.
3. To develop effective case management skills.
4. To gain a better understanding of clinical consultation with a critically reflective lens.

Below, I will expand on the aforementioned learning goals and detail their importance to the successful completion of my purposed Advanced Practicum. The importance and relevance of critical reflection and the use of self has been presented in the literature review above and my personal reflection of its implementation within my practicum will be explored in greater detail in the subsequent reflection chapter.

Perspective of Pre-structured Power Imbalances among Multidisciplinary Team Members

Due to the current social trend of holistic care, there has been a strong shift to incorporate social work as a part of a multidisciplinary team. Loucks-Campbell (2011) notes that this is especially true within medical settings, as social work's addition offers the client the opportunity to receive non-medical support in addition to medical intervention (Turner, 2011). During my time with both the in-patient psychogeriatric unit as well as with the out-patient BSO team I have found the role of social work to be an important one when working alongside geriatrics, particularly when examining mental health aspects. Often times there are social prejudices that are perpetuated throughout various areas within an elderly individual's life. This can be easily

viewed within the medical setting; for example if an older individual contracts an infection that goes untreated they are risk of developing a delirium. As a result of the delirium, they can become confused, unable to remember common things, engage in peculiar behaviour etc. Often times this is seen by caregivers, or care providers as a natural deterioration based on age. If the elderly individual had lived at home, often there is awkward as written the discussion about Long Term Care Homes and 'placement'. Should the elderly person have a history with ill-mental health, these changes/behaviours can be interpreted as the result of a psychiatric condition. Although these are each important things to consider, it is imperative to advocate that these be ruled out and not simply accepted as fact. This is one of the places in which social work has a role to play with this population. More specifically, a critically reflective approach to social work practice plays a part through challenging the pre-structured power, language, and knowledge biases that are held and considered to be 'acceptable' within society.

It is reported however, that often within a multidisciplinary team, especially within a medical setting, that the importance of social work is often diminished (Turner, 2011). This in turn can lead to conflict among team members and feelings of under appreciation could be perpetuated.

With the comprehensive multidisciplinary team on the Psycho-Geriatric Assessment Unit, I found that there was much to learn about various roles and perspectives. This layered view of a multidisciplinary team was beneficial in enhancing my practicum experience, as I sought to cultivate reflective skills and gain a valuable understanding of group/discipline dynamics within a medical setting. I was also able to gain a perspective on social work's position within the group in relation to other professions both within the in-patient and out-patient teams and the hospital as a whole.

Gerontology is described by Alkema and Alley (2006) as a unique discipline within which theories of aging are conceptualized from an interdisciplinary perspective. Given the fact that adults are on average living longer, including those with pre-existing mental health conditions, the assessments provided by those who are working along-side these clients must reflect their increased complex needs (Berkman, 2011). In the early 2000's, multidisciplinary health teams were seen as a cost effective way to provide older adults with an enriched quality of life, a focus on active living/health promotion and disease prevention (Berkman, 2011). Daley (2010) and colleagues have also posited that critical reflection and reflexivity can be pivotal to engaging in and producing ethically sound research and knowledge. This is obtained through the acknowledgment of power and structures that permeate the practitioner's and participants' experiences, the process of research, and the construction of the knowledge itself (D'Cruz, Gillingham, & Melendez, 2007; Fook & Gardner, 2007). By problematizing the concept of 'professional' practitioner knowledge, the pre-structured power imbalance between practitioner and client can be challenged and examined (Fook, 2012). Foucault (1988) cautioned that "every relation is a relation of power linked to knowledge construction...it is neither good nor bad but it is dangerous" (as cited in Miehl & Moffatt, 2000, p.342). It is because of this inherent power imbalance that naturally occurs in a therapeutic relationship, that social workers must constantly be aware of the areas in which they hold power and how they exercise that power. This is particularly true when considering structural power imbalances already in place for clients outside the therapeutic relationship.

Power and Multidisciplinary Roles on Unit 4-6

A large portion of my practicum was based in a hospital setting with a multidisciplinary team on the in-patient psychogeriatric assessment unit. The "problems" associated with aging are

multidimensional and therefore must be addressed through a multidisciplinary team (Alkema & Alley, 2006). Team members on the unit consisted of psychological associate, the medical director of the unit (M.D.) who specialized in geriatrics, a chaplain, an occupational therapist and occupational therapy student, an occupational therapy leisure aide, a CCAC case coordinator, nursing staff as well as nursing students, the manager of in-patient and out-patient psychogeriatric and mental health services, the nursing coordinator, a dietician, the BSO coordinator, and team members, as well as a ward clerk, and pharmacist. I quickly came to understand and appreciate that all team members were involved in the process of assessment and support of patients from admission to discharge plans, from transitioning and beyond. During this process I found that at times there would be conflict among roles when examining expectations versus realistic abilities. This seemed to be present when there was a breakdown of communication between disciplines, or if there were unclear parameters surrounding what a discipline believed to be important for the patient's care plan in terms of their assessment. It is also possible that there was a lack of understanding surrounding the role of the social worker in a multidisciplinary setting. Alkema and Alley (2006) posited that this was a main reason why those who work in multidisciplinary teams in geriatrics have traditionally found difficult. This is particularly true when conflicts between the various disciplines in conjunction with the various issues of aging arose. Whereas some disciplines held value within the medical aspects of the patient, others were more concerned about the spiritual and social wellbeing of the patient. To aid in addressing this, rounds were held early in the week and any family conferences/discharge planning meetings held at the end of the week. This served as an opportunity for all members of the in-patient assessment team to come together on a bi-weekly basis and share updates on all the patients currently residing on the unit from the perspective of their discipline's assessment, and

identify next steps. One way to examine this power is to understand where the concepts for these shifting power dynamics come from, why they are accepted and how they can be influenced and perpetuated through ideologies, language, discourses, and narratives of practitioners. In order to gain a better understanding of the roles of the various disciplines involved on the unit, the key roles of the multidisciplinary team, as I witnessed them, are detailed below.

Power and the Role of Medical Director

The physician on the unit is in charge of providing a diagnosis, and medical care as well as ordering any medication changes for patients on the unit. As per the Mental Health Act (1990) the physician on the unit is also in charge of assessing a patient's capacity for finances. Should they be found 'not-capable' the physician is also responsible for completing a Form 21, which enacts a person's Power of Attorney (POA) for property should they have one. In the event that a patient does not have a previously assigned POA for property, the physician is then legally obligated to complete and submit a Form 22 which awards POA for property to the Public Guardian and Trustee (Mental Health Act, 1990). This places both a lot of pre-structured power and a lot of responsibility with the physician. The MD holds not only the ability to make life-changing decisions for the patient, but also to make the final ruling on the patient's ability to make their own decisions. If the MD's decision is contested by family/patient or outside body, it is his or hers license that is at stake. Although I was not able to spend much time shadowing the physician on the unit, I was able to engage in clinical consultation with my supervisor in relation to this power, while recognizing that an individual has the right to live with risk so long as they can appreciate that risk.

Power and the Role of the Occupational Therapist

The occupational therapist on the unit is charged with assessing a patient's competencies and physical abilities. They often perform a cognitive test called the Montreal Cognitive Assessment (MOCA) (Nasreddine et al., 2005) this helps to test different parts of the brain and provide assessors with information as to what cognitive areas, if any, the patient is experiencing difficulty with. In addition to cognitive testing the occupational therapist performs a kitchen assessment which is an exercise in instruction and safety to see how an individual would be able to function on their own within a home setting. Although this kitchen assessment is thoroughly explained to the patient, it is not given within the patient's home where they are more familiar with the setting and equipment. There are unfortunately not enough resources to have this assessment conducted within the community. Additionally, it provides the assessor the ability to assess the patient's ability to follow commands and to gauge short term memory for impairment. The result of this assessment impacts the report provided by the OT and factors to some degree into the eventual decision of the MD. The occupational therapist also examines a person's rational ability by providing them with situational questions and determining if they are able to appreciate the risks and benefits of their situation and potential next steps. The physician relies heavily on the OT's findings in the kitchen assessment and with the MOCA testing to help make discharge destination decisions.

Power and the Role of the Occupational Therapy Leisure Aide

The OT leisure aide on a unit works to provide programming opportunities for patients, whether it is one-on-one or in a group setting. These activities are varied depending on the physical and intellectual abilities as well as the interests of any given group of patients. A large part of the OT leisure aide's role is to engage patient in psychosocial rehabilitation and to assess

how they engage in group or individual activities. This helps to determine how a client would do in a care setting with programming such as Long-Term Care, Retirement Home, or Day Away Programming. It also serves as assessing effective non-pharmacological behavioural intervention options as often time's behaviours occur as a result of boredom with patients who have dementia. I was able to participate in several music based group activities while on the unit, and since much of my academic work has surrounded dementia and music therapy, it was an enlightening opportunity to see the impact that music can have on responsive behaviours.

Power and the Role of the Nursing Staff

Nursing staff on the unit are in charge of the front line care of the patients. In addition to administering medications, they are also responsible for assessing what levels of assistance a patient needs with cares, eating, hygiene, and general interactions with other patients and staff. As front line workers, nursing staff also spend a considerable amount of time intervening with patient behaviours and implementing both pharmacological and non-pharmacological interventions. As the hospital unit is set up to mirror a LTC setting, the nursing assessment helps to determine what level of care a patient may need upon discharge. Based on the environment nursing staff are also able to ascertain if a client would thrive in a LTC setting. As frontline staff, nurses also have the power of medication administration. Many of the patients on the unit have a PRN order, which is an order for medication as needed. At times the PRN medication ordered was for Haloperidol, which is a strong sedative drug. Although this medication was to be given only during times of increased or critical levels of physical aggression and agitation, depending on the subjective level of comfort of the nurse in charge of that patient's care, the threshold for acceptable levels of agitation was a demonstration of a huge power imbalance for the nurse over the patient.

Power and the Role of the Social Worker

Working with the social worker on the unit, I was able to experience and participate first hand in completing social assessments on the client which includes personal, social, educational, and professional history as well as a significant medical history (relatives with dementia etc.). Many of these areas can help staff to not only gain a better understanding of who the patient is as a person but also who they were previous to the onset of dementia. This can also help to explain some behaviours and avoid misinterpreting them. In addition to this, the social worker would also spend time with the patients on the unit to gain a better understanding of where the patient was functionally and to address any wishes the patient may have, as well as to help identify effective non-pharmacological interventions. The social worker also served as the main point of contact for the family. It is for this reason that the social worker would organize the family conference for discharge planning and would facilitate this meeting. The social worker on the unit would also make any and all appropriate referrals for community support should the client or family require it. Lastly the social worker also worked with compiling the client's documents, then sending the Form 22 to enact PG&T POA for property for patients with POAs previously assigned.

As per the roles described above, a patient receives a comprehensive assessment during their time on the unit. Once an assessment of a patient is complete and effective interventions in place, it is then time to complete a discharge plan and a family conference is called. During these meetings the social worker acted as the facilitator of the group however it was the MD who ultimately made the final decisions about patients on the unit. The hierarchy of knowledge places the highest value on technical or scientific knowledge, and knowledge founded through intellect (Fook & Askeland, 2007). However, that is not to say that during the bi-weekly meetings that all

parties were not offered the opportunity to share their findings/update the group about their beliefs in relation to the patient as per their assessment roles. Whether observing or participating in these meetings, I found that there was a genuine, conscious effort on behalf of the MD to take each discipline's findings into account, despite the final say being his or hers. However, the fact that the MD was to make all the final decisions was not met with frustration by fellow team members, rather more a sense of relief as they were also then not responsible for any potential negative outcomes from decisions made. In addition to the legal system, many roles also had to adhere to their professional colleges and associations, which were also seen as a form of positive structural power.

In detailing these roles, it puts perspective on the objectives and values that each discipline places emphasis on during their assessment. It also highlights the importance of building a cohesive assessment of the patient's mental and physical health that is inclusive of each part. There must be cohesion across biological, psychological and social practices in order for gerontology to be addressed in a unified way (Alkema & Alley, 2006). Multidisciplinary mental health teams are better than monodisciplinary teams at meeting the complex, long-standing mental health needs of a person. This is because multidisciplinary teams are able to provide a more holistic support and perform timely assessments with the client (Abendstern et al., 2014). Although older adults value a trusting relationship, the medical/assessment model for geriatric mental health poses time constraints that impede these relationships from forming (Abendstern et al., 2014). During my time on the unit, assessments of a patient could take anywhere from two weeks or more; this depends on the goal of assessment and the patient's progress, as well as their discharge destination. However, there was constant pressure from the hospital administration to keep a high level patient flow through the unit due to bed shortages

and the growing demand for assessment. Alkema and Alley (2006) supported this finding as they found structural barriers prevent the sharing, communicating, and understanding of an interdisciplinary knowledge base and are often reinforced by a lack of multidisciplinary support from the institution itself. Despite this, there is still the right for each patient to receive a comprehensive assessment, yielding results that are beneficial for all involved.

Power of Gender, Age and Language on Unit 4-6

Although there was a conscious effort to minimize the power imbalances among members of the multidisciplinary team, there are still notable pre-structured power imbalances observed. On the assessment team, the majority of members were female with the exception of two males: the MD and the occupational therapist and, infrequently, male nurses. Living in a neo-liberal, patriarchal society, value is often placed on males to have higher power, more assertive roles in the workplace whereas females are often depicted as the nurturing, supportive role (Mahon, 2008). The distribution of genders on the assessment team visually represented this assertion, as the roles that the female staff held within their caregiving professions (nursing), were lower on the hierarchy of power than the male MD.

In addition to the unequal gender representation on the unit, there was also a disparaging divide on age among staff. All the same I was a student, in my late twenties; I was by far the youngest member on the team. Although I was competent and skilled enough to keep up with the pace and meet the demands of providing social work support on the unit, staff would often make comments about 'how mature I was for my age'. Though these statements were meant to be complimentary, and empowering in nature, they also served to reinforce the pre-structured power they had as an adult who was a working professional. Within the critical approach, power, and the notion of empowerment need to be examined as fluid concepts within the lenses of diversity,

context, and perspective (Fook, 2012). As Foucault (1980) asserted, power is not always empowering, and has the ability to disempower an individual as much as it can be a beneficial support for them. Power is expressed within micro, casual relationships, and is developed within the same (Healy, 2000). Over the course of my practicum, I was able to slowly move towards a more equalized power between myself and the members of the team. I achieved this through the development of personal relationships with many of the staff, using my sense of humour to reframe their comments and bring attention to their power.

The power of language was permeable to all disciplines on the unit. This became my steepest learning curve during my practicum at the hospital, as medical terminology was given precedence as the common language and was assumed to be understood by all disciplines regardless of background. Although this was understandable given the hospital setting, as a social worker I found that I would also have to alter my language in order to participate in patient conversations. There were several phrases that held particular power on the unit and were commonly used to describe a client's behaviours. Two key phrases were 'medication compliant or not medication compliant' and 'capable or not capable'. I found this language to be so powerful and as a result, I often discussed this with my supervisor during critical consultation. I believe that it was important to consciously avoid using these phrases while working on the unit to try and reduce, in a small way, the power that this language held. Instead of saying "not medication compliant", I would often try to find out why someone was refusing their medication (time of day, effects, taste, etc.). In both my interpersonal conversations with other staff on the unit as well as in my documentation I challenged myself to always expand, where possible, the reason for the choice to not ingest medication. I chose to seek out this additional information rather than just labelling their behaviour with terms that had a negative connotation. As

discussed, language is an integral component of critical social work practice, and in turn critical reflection. The terms “not compliant” have a negative foundation suggesting that the person who is engaging in behaviour that is not compliant is being difficult and not conforming to the norm/rules. This can then go on to have the individual labelled as “difficult”. Instead of perpetuating this, I felt it was important to take a step back and assess why medication was being refused. Sometimes it was as simple as the individual did not want to take their medication, which is their right. Other times the medication was difficult to swallow, tasted poorly or even caused stomach upset. In cases where there was a specific issue with medication administration, such as the medication being difficult to swallow, there were measures that could be taken to address this i.e. crushing medication, placing them with applesauce. Within my documentation I would not state that a patient was not medication compliant; rather I would say patient did not wish to have medication administered at this time. Although this phrase takes slightly longer to convey the message it does it in such a way that is not immediately negative in tone.

In addition to gender, age, and language, race was also a source of power on the unit. During my time on the assessment unit all members of staff were Caucasian which places them within a racial group that has pre-structured power with Western society. This was an aspect of power that it was important to be cognisant of, but was often easily overlooked given the lack of diversity among the multidisciplinary team. Like staff, many of the patients on the unit were Caucasian; there was only one patient during my time there that identified themselves as First Nations persons. Seeing a predominantly Caucasian group of both staff and patients was not surprising to me as both Grey and Bruce counties are comprised of a predominantly ‘white’ population. I believe this helped to normalize the ‘whiteness’ of the team and therefore made realizing race as a form of power difficult for staff on the unit. When completing an assessment,

I would always make sure to ask how the person wished to identify themselves in terms of race as I did not want to presume race, nor did I want to assert my power as a white person through language and force an identity upon them based on my assumption of their race.

Power within the Community Mental Health Field: Nursing and Social Work

A common assumption about nursing and social work in my personal experience with mental health services, both in community and hospital settings, is the belief that nursing staff perform the same role as social workers. This may be, in part, due to the fact that social work continues to have an ambiguous role within the medical field. Within their study on multidisciplinary community mental health teams, Carpenter et al., (2003) found that social workers had higher levels of dissatisfaction within multidisciplinary mental health teams due to role ambiguity, or clashing of professional values within a medical vs. social framework for mental health. This is emphasized as much of the professional credibility within a mental health multidisciplinary team is placed on a medical hierarchy which values medical interventions and its knowledge base. As such, Carpenter et al. (2003) propose that increased support through supervision was an integral way to combat feelings of frustration on the team. Abendstern et al. (2014) agreed with this assertion and went on to note that social workers often regard their role in a multidisciplinary team as being seen as less than other more defined roles. This is believed to be due to a lack of understanding from other team members about social work practice and the role that a social worker has within a mental health setting (Abendstern et al., 2014). I believe this in turn is part of a larger conversation about social work in general and the belief that social work as a “profession” has historically been difficult to define. According to critical social work practice language this is one reason that social work is defined as a practice rather than a profession. This leaves other professions to try and alter or adapt social work into a standardized

role, especially within the medical field. With this lack of understanding, it is important for social workers to be constantly aware of their role as well as their limitations (i.e. medication monitoring) (Abendstern et al., 2014). I found these assertions to be founded in practice during the portion of my five month practicum I spent with out-patient BSO mental health team. I will discuss these observations and how I was able to interpret them in greater detail in the following reflection chapter of this document.

On the BSO team I have found that the social worker often had to justify their role both to colleagues and at times their supervisor. Whereas others on the team saw this behaviour as the individual social worker's personality, as a student, I was able to appreciate it from an outside perspective informed by social work literature. As a social worker on a team that is dominated by nurses (6:2) with a team coordinator and manager who are also nurses, it was understandable that the few social workers who are on the team have to work harder to educate other team members about the roles a social worker can have when working with a client and responsibilities that a social worker has ethically.. On the mobile team, all clients are placed on one shared caseload for all team members to follow. The only exception to this is with social work clients. There were members of the team that were quick to suggest or offer referrals for certain clients, to the social worker especially if there were larger family dynamics involved with the client's situation and behaviours. Although this is understandable and an effective way to ensure that those who could benefit from social work support are being seen, at times it also appeared that clients with more complex needs were referred to the social workers. Although any clinician can follow up with any client, the feeling I observed from the mobile team was that those receiving social work support were left solely for social work to follow-up with. Unlike the in-patient unit, clients receiving social work support on the outpatient mental health team were noted with specific

social work distinction. Within their study Abenstern et al. (2014) noted that social workers often preferred to have a social work distinction on older adult clients that were being supported by a multidisciplinary team who required increased social support. I felt that the social workers coveted this distinction to justify their role on the team. It is reported that often within a multidisciplinary team, especially within a medical setting, that the importance of social work is often diminished (Turner, 2011). The power imbalances between disciplines with the mental health field are prevalent, particularly between nursing and social work.

Interdisciplinary Social Work Power

Although I bore witness to pre-structured power imbalances between the multidisciplinary roles during my practicum, I found that there were vast differences between how this structural power affected social workers working with in-patients versus out patients. Whereas on the out-patient team the social worker strives to carve out and educate the needs for social work within the team setting, the in-patient social worker is able to practice social work assessments without a significant amount of conflict. I believe this may be in part related to the process within the out-patient mental health team of receiving social work support only if it is found to be warranted by another staff. In contrast, the in-patient assessment unit incorporates the role and assessment of the social worker consistently with each patient that is admitted to the unit. That being said, there are drastic imbalances of power between the social worker on the in-patient unit versus the out-patient team. Whereas the out-patient social worker performs in a consulting role (as per the teams function) the in-patient social worker's subjective findings are presented to the MD who has the ability through pre-structured power to take these findings and make life-changing decisions that affect the patient (ability to drive, manage their finances etc.). It is for this reason that it is important for social workers to constantly engage in critical

reflection and problematize social work practices and acknowledges their subjectivity, and to ensure that it is explored in order to engage in ethical practices, especially within geriatric mental health.

Case Management

Case management is an integral part of social work practice. Through case management, social workers are able to support vulnerable individuals within a fragmented system of human service organizations, in an effort to ensure that all individuals receive the support needed (Rothman, 2002). Social workers engaged in case management must be able to work with clients at both an individual and community level, so as to ensure that there is a sustainable continuum of care within the desired setting (Rothman, 2002). Sullivan and Floyd (2012) stated that it is hard to maintain objectivity in case management given the intense and immersive therapeutic relationship. As within the critical reflective approach, it is acknowledged that believing one can practice objectivity is an elusive, and futile notion. It therefore becomes even more important to engage in critical reflective practice and explore the use of self for social workers; especially in case management settings. Case management is generally an intensive therapeutic support that a social worker offers their client. Over time, it is impossible to not have your experiences with your clients affect your social work practice, just as it is impossible for a social worker to ignore their social, political, and historical influences that have helped to shape their practice initially. It would be hard to display various traits synonymous with social work practice such as empathy whilst maintaining an objective approach to social work. Without characteristics such as this, engaging in various social work roles; including advocacy and counselling become ethically erroneous. In accepting subjectivity as an active part of social work practice, participating in

critical reflective practice acknowledges this, while allowing the social worker to engage in ethically sound practice, particularly in case management settings.

Austin and McClelland (2009) note that in addition to social work practice, case management is an integral aspect of older adult community care. The result of a fragmented system, case management provides social workers with the ability to aid their clients in system navigation (Bogo, 2006). This is particularly true when exploring the social, political, and health-based pathways for older adults with dementia in rural Ontario. There are varying forms of case management that a social worker can engage in, depending on their agency mandate/structure and the population served. During my practicum, I had the opportunity to engage in Organization-Based Case Management (Woodside & McClam, 2006). Woodside and McClam (2006) detailed this structure as a single point of access for client support that encompasses intake, assessment, care-plan development, and transitional support. With both the in-patient assessment unit and the out-patient mobile services, following an organization-based case management structure was most appropriate as it is based in a wholistic approach to assessment with multidisciplinary input (Woodside & McClam, 2006).

Case Management: Psychogeriatric Assessment Unit

During my time on the in-patient unit I shared in the case load with my on-site supervisor as the unit housed only sixteen patient beds; however I was able to take the lead role on several patients during the course of my five month practicum. The patients that I was able to support on the assessment unit all exhibited responsive behaviours which included but was not limited to: physical and/or verbal aggression, sexually inappropriate behaviour, wandering, and harm to self often due to dementia disease progression, at times in conjunction with additional physical/mental health concerns related to aging. Case management on the in-patient unit was a

unique situation in so far as there was no formal intake for social work to perform, as the MD competed the intake to the unit which automatically placed the client on the social work caseload. However, I was able to complete several social work assessments on various patients during their time on the unit. These assessments included social, employment/financial, health, and personal history; current/relevant supports formal and informal, client and family wishes for admission and discharge. In the event that the patient was not able to provide any or all of these, then a family member or close friend (either the client's Power of Attorney or next of kin) was contacted to corroborate any collateral information. The social work assessments on the unit were integral to gaining a better understanding of who the patient was in the past and who they are in the present. This also helped to connect with family/friends of the patient and to offer additional support to them, while their loved one was admitted on the unit most commonly with the First Link program through the Alzheimer's Society.

Case Management Skills: In-patient Unit

Due to the time constraints in place for assessment on the in-patient unit, I was able to develop and hone various clinical skills for short-term assessments. The skill that was most challenging for me to demonstrate was the ability to build rapport quickly. Given the short term stay a patient can have on the unit, it was important to be able to build a trusting therapeutic relationship quickly. As case management requires engagement between the client and the practitioner, the tumultuous nature of some mental health conditions, as well as varied individual experiences, both past and present, building the required trust for such engagement can be daunting (Sullivan & Floyd, 2012). I found that beginning with the patient through an informal conversation, was the best approach to allow the client to set the pace of the interaction. If it was possible I would avoid reviewing the client's chart prior to this meeting to help suppress any

biases; for safety at times however, I was informed about any behaviours that the patient was exhibiting which could cause harm. Additionally, active listening, concise yet relevant documentation skills, as well as the use of semi-structured approaches to obtain collateral were all skills that I was able to employ while on the unit.

Contemporary case management in mental health generally shares much of the requirements found within the medical setting, focused on resource availability and goal achievement. This can, at times, prompt a practitioner to attempt to set the pace for the client (Sullivan & Floyd, 2012). I had to work diligently near the end of my practicum to ensure that I was not trying to create a client care/discharge plan prematurely. I spent considerable time reflecting on the importance of active listening and critical reflexivity in practice. By the end of my time at practicum I was more confident in performing a comprehensive and individualized assessment with each client, and placing the time constraints put in place by the hospital in perspective of the social work practice/process I was engaging in with each client. As clients and their cognitive ability were distinctive, each assessment was in turn unique, as were the theoretical/ideological practice approaches I was able to draw from. I was able to work within my eclectic theoretical approach to practice to support the goals and meet the needs of the client and their family. Sullivan and Floyd (2012) advised that effective case management skills are maintained by possessing a varied theoretical and practical skill set which can be utilized for the capricious journey of supporting a client and their ever-changing concerns/needs. As previously mentioned, rounds and family conferences were held bi-weekly on the unit. During these information sharing sessions with the multi-disciplinary team I was also able to present my assessment findings. This in turn aided my presentational skills which are important for concise and timely updates within a medical setting.

Through my time on the in-patient unit I was able to develop and hone many skills related to case management from a social work perspective. These initial skills were complimented and enhanced by the work I was able to do with the BSO mobile team.

Case Management: Out-patient Mobile Team

As my practicum was divided between the in-patient psychogeriatric assessment unit as well as the BSO mobile team, I was provided the opportunity to also partake in case management duties within a community-based setting. As a part of the mobile team that was affiliated with the in-patient unit, I was able to continue to follow many of the patients that I had assessed in hospital and discharged into the community. I appreciated this as the rare opportunity it was to fully explore the continuum of care that occurs when a patient is discharged from the assessment unit and transitions as a client into a community setting. While working on the BSO team I was able to shadow both the imbedded social worker on the team as well as the part-time social worker provided to the team by the Alzheimer's Society. In doing so, I could follow many of the clients on service with BSO that were supported by these social workers.

Unlike the psychogeriatric assessment unit where the MD received referrals and made admission decisions, the referrals for the BSO team could be made by anyone professional or personal. The intake process was completed by the clinicians themselves (nursing and social work). In order to be eligible for services, the person being referred had to be over the age of 65 and have a diagnosis of: dementia, a mental health diagnosis, or be engaging in substance abuse and must be exhibiting responsive behaviours. The BSO team's intake process was very structured. As this program is funded by the LHIN, the BSO team has to provide a detailed report on all client contact, and insure that the intake is completed within two hours of receiving the referral, and the assessment completed within forty-eight hours after completing the intake.

Any clinician on the team could receive and complete an intake and assessment on a client. However, as mentioned, should a client require social work specific support from the BSO team, then an internal referral was made (usually informally) to the social workers on the team. Whereas the in-patient caseload was capped at sixteen patients, the social work caseload on BSO was constantly fluctuating.

Though the intake unearthed basic information about the client, the BSO assessment process was completed under a PIECES framework (Hamilton, Harris, Le Clair, & Collins, 2010). PIECES stands for: Physical health, Intellectual health, Emotional health, Capabilities, Environment, and Social history, these overarching topics are deconstructed further below (Hamilton, Harris, Le Clair, & Collins, 2010). By being able to study and practice this framework with clients, I was able to enhance my process of assessment in case management.

Case Management Skills: BSO Team

Developed by Hamilton, Harris, LeClair and Collins, PIECES is an assessment framework specifically developed for older adults who have physical and or mental health concerns, as well as responsive behaviours (2010). I found that the framework is comparable to the person-in-environment approach to social work practice but it slightly more structured in its approach to gathering collateral. Through this framework the following is assessed:

Physical – any physical considerations that could be contributing to the client’s behaviour

(medication side effects, diagnoses etc.);

Intellect – identify what intellectual abilities the client has or is having difficulties with

(e.g. do they have insight to their condition);

Emotion – any mental health diagnoses or mood regulation difficulties that impact emotion that could be contributing to the client’s behaviours (eg. depression, anxiety);

Capabilities – is the person able to self-care, and to what degree (eg. can they go

grocery shopping on their own, do they need assistance with care);

Environment – are there any external stimuli that could be impacting the client and causing

behaviours (eg. too much noise, change in lighting);

Social – explore the client's social background and highlight areas that were significant for the

client (both positive and negative). This helps you to have a better understanding of the

individual's life history as well as providing information about any past events that could be

having an effect on the client at this time (Hamilton, Harris, Le Clair, & Collins, 2010).

I was able to take the social assessment skills that I had developed working on the in-patient unit and incorporate the framework of PIECES as well to be used as a guide for assessment. By familiarizing myself with this framework, I was able to reflect on the information of varying aspects of a client's life that could have impact on their behaviours. Through this, I could then exhaust non-pharmacological suggestions/options to address responsive behaviours prior to, or at the very least in conjunction with any medication changes suggested by the MD.

In addition to enhanced assessment skills, I was also able to cultivate abstract thinking and advocacy skills during my time with the BSO team, whether that be through referrals for tertiary client support or simply by exploring non-pharmacological interventions. The responsive behaviors of the client I was able to support often required an abstract solution in addition to clinical service. Often times when seeking additional support or offering suggestions of intervention, I found my clients' referrals being rejected for a multitude of reasons: because they failed to meet specific criteria, they could not be supported within their residence, they were involved with our team and additional mental health support that would be a duplication of service or other barriers. It was in these instances that I found the need for advocacy within a

system that seemed to focus more on screening out than screening in. When possible, I spent time working with clients and their families to support them in advocating on their own behalf. When this was not a possibility, I would have to advocate on behalf of my client. Witnessing the process within the hospital setting, as well as previous practitioner and personal experience of community and social supports for older adults with dementia, I was able to draw upon my prior knowledge to also advocate on behalf of clients. Through practice of active listening, reflection, mindful response, shadowing, and constant consultation with the social workers on the team, I was slowly able to find a personal balance between diplomacy, passion for social justice, and my as well as the client or family's frustration.

Through my practicum work with both the GBHS and BSO teams, I had the opportunity to be assigned my own caseload. This enhanced my direct practice experience on both individual and community based levels. Additionally, I was supporting individuals and their families who accessed other services within the community with which I had the opportunity to network. My goal to develop direct practice skills that are transferable to individuals and groups within a broader community context was supported through this experience. I was able to strengthen my client-practitioner relationships through supporting my client's transition into the community.

Consultations with a Critical Lens

Failing to problematize social work practice promotes an unattainable culture of objective assessment, silence, and individualism, wherein the dichotomy of "correct" or "incorrect" practice is perpetuated, which in turn places pressure on the practitioner to avoid being "wrong". This pressure (anxiety) is noted as the most common barrier to reflection (Ruch, 2002; Fook & Gardner, 2007). In contrast, Trevelyan, Crath, and Chambon (2014) assert that feelings of uncertainty and anxiety are necessary experiences for critical practitioners who wish to engage in

truly ethical practice. Here, critical reflection calls for consultation, as a way to support the practitioner on their journey and to normalize feelings of anxiety and concern (Ganzer, 2007). Consultation within the critical approach helps to transform practice to encompass more empowering, ethical, and effective experiences for both the practitioner and the clients. This is done by allowing the practitioner a safe space to debrief events related to practice (Marlowe et al., 2014).

As previously mentioned, I was able to engage in critically reflective, clinical consultation throughout the course of my practicum with various social workers in supervisory and collegial roles. In addition to these, I was also able to reflect throughout the five months of practicum and review my practice through my own journaling with a critical lens. Though much of the context and substance of the journaling topics and critical reflection will be unpacked within my next chapter, which details my personal experience and perceptions of my practice within practicum, here I detail the framework with which I was able to incorporate critical reflection into my consultations in order to gain a better understanding of this form of social work practice.

Consultations with Colleagues and Critical Self-Reflection

Throughout the course of my practicum I had decided to keep a daily journal of my practice experiences and review them on a weekly basis to identify any themes in my thoughts/actions/perceptions that week. I had decided to frame my journaling with key critically reflective questions offered by Fook and Gardner (2007) which will be explored further with the reflection chapter. In doing this, I was also able to identify various growth edges within my own practice and could then work to change them. In keeping with the critical lens, I would also be sure to evaluate my personal feelings of my work week and try to look at various aspects of my personal life that could also be influencing these. By keeping a detailed journal of my experience

and practice skills I was able to identify areas within my practicum that I found to be frustrating. For example, finding resources and support in the community for older adults with dementia is extremely difficult due to the limited availability of services, particularly within rural areas. This leaves much of the responsibility to the family. On several occasions, family members (often the spouse) would be the sole support and caregiver for the patient. If following an assessment a patient was not safe to return home, they would leave hospital and go to a LTCH upon bed availability. Although there was minimal transitional support for the patient, there was no real transitional support for the family. I realized that my grandmother was very fortunate to have received the support she did from my grandfather and our family. It also allowed me to have perspective of the power that my knowledge and the experience I had gained during my years in university and through my community work had provided our family during our transition. Realistically, I understand that in order for sound support to be offered, there first needs to be funding available for people to access. This in turn solidified my belief that there is macro change needed from the government to develop and implement a pan-Canadian dementia strategy that would serve to better support the 14% of Canadians who are living with dementia, as well as their more than 1.3 million caregivers (Alzheimer's Society, 2012, p. 1). This could be accomplished through education, community and transitional support that is person-centred, and easily accessible knowledge and resource sharing that is available for the general population. In addition to my direct practice, critically reflective journaling has also put some of the greater structural barriers in perspective and helped to set new personal goals for future practice and advocacy alongside this population.

Journaling also provided me with the outlet to be able to focus on my interactions with each individual patient and see how each experience was unique. This in turn helped me to

continuously challenge assumptions that I held about people with dementia, caregivers, geriatric social work, and responsive behaviours in mental health. Fook and Askeland (2007) stated that one goal of engaging in critically reflective practice is to allow the practitioner to recognise and examine various social, cultural, and structural assumptions they hold, especially in relation to power, in order to foster transformative practice. In challenging these, I was made more aware of my past personal experiences and how they could influence my subjective outlook. By understanding and acknowledging this, I was better able to keep these experiences and thoughts in perspective, thereby engaging in continued ethical practice. Reflections on my personal experiences and challenges in practice are explored further in the following reflection and conclusion chapters.

In addition to my personal journaling, I also had the opportunity to informally engage in debriefing my practicum experiences within my MSW peer group throughout my practicum. Here I was able to find comfort in sharing my thoughts/feelings/fears of my practice style and approach with peers who would then pose questions or offer feedback in a way that was both validating and challenging. This experience helped me to normalize some of the feelings of anxiety and discomfort I initially felt within my practicum, as well, it forced me to truly explore why these feelings were occurring. It also highlighted other areas of my practice that I had failed to identify. I was also able to receive feedback or have other critical questions posed to me that would offer additional or deeper viewpoints than I had identified enhancing my reflections and goals for practice.

I did not share my journal with my supervisor, as much of my reflections were personal in nature. I was however able to share thoughts/experiences with her which offered yet another perspective.

Consultations with Practicum Supervisor

By reviewing my personal journals I was able to give some guidance to my consultations with my practicum supervisor. While engaging in practice on the in-patient unit I was able to meet bi-weekly with my supervisor to explore my practice skills. I felt comfortable disclosing concerns I had about my own practice and gathering feedback from her. My supervisor was very proactive in ensuring that I was able to work towards and through the goals and growth edges that I found during my personal reflection. During our discussion we would often discuss things informally within the critically reflective framework outlined by Fook and Askeland (2007):

1. What happened?
2. What did you do?
3. Where were you coming from?
4. How did you react?
5. How did others react?
6. What is important about this?
7. Where might you go with this?

Through the exploration of these aspects of the various situations and actions that I encountered during my time at GBHS, I was able to debrief about my concerns and feelings. At times, while engaging in consultation with my supervisor, I had strong feelings of anxiety and thoughts that I was not truly engaging in social work practice. I often reflected on missed opportunities with patients. My supervisor was always very open and honest with me about my skills and practice ability and would often offer her own reflections of my performance. She was transparent in her own actions as well and this again was beneficial to my learning experience as she was able to model her own reflections as well.

Having the opportunity to debrief with her allowed also me the opportunity to vent frustrations with the GBHS' approach to social work. As my supervisor had been in her current role for a number of years she was also able to offer much of the environmental context and collateral about social work in the hospital, how it had changed, and how it once functioned versus how it functions now. This helped to bring an additional layer of context to my critical approach to practice within the hospital setting, and a stronger appreciation for engaging in consultation with my social work supervisor. For example; where once there was a social work department at GBHS there is now a program based system. This means that instead of there being a social work department, the departments are based on the medical function they provide (mental health, geriatrics). This leaves social workers to have supervision with their managers. In the case of the psychogeriatric unit the manager is a nurse. In light of this the in-patient social workers gather monthly in a grass-roots style meeting to discuss concerns/issues that are specifically related to social work. I was able to see small ways that the in-patient social workers of the hospital were challenging the current system and working to create change. By engaging in these meetings both my supervisor and I were able to receive and offer consultation to the social workers of the hospital.

Lastly I found that through discussion with my supervisor I was able to explore my use of self within clinical and group settings. Whether completing an assessment on a patient or presenting and engaging with the patient's family during a discharge conference, I was able to reflect on my own personal style of practice. Use of self was a large part of my reflections, both in my personal journaling as well as with my supervisor. This helped me to give perspective to my choices of humour, touch, and language with patients and to explore them to remain within

the ethical parameters of practice. I wanted to ensure that my use of self was continuing to do no harm to the patients and was in their best interest and not a personal need.

Through my practicum I have strengthened my resolve that critical consultation fosters the best transformative feedback from my supervisors. It opened up a dialogue surrounding my direct practice between other staff, my peers, as well as myself. Consultation was also used to review my reflections in direct practice with older adults, to ensure that personal narratives, discourses or biases are not negatively affecting my practice. Additionally, it served as a channel through which personal anxieties were explored and supported, not only enhancing the educational aspects of my practicum, but also increasing my awareness of self, thereby challenging my knowledge and identity within a direct practice setting.

Summary

My practicum experience at GBHS with both the in-patient psychogeriatric unit as well as the BSO out-patient team provided me with opportunities to explore and complete my learning objectives through clinical case management and assessment. I was able to shadow and work alongside various disciplines, which provided me with a greater understanding of context to review through a critical lens. I was able to gain valuable knowledge and social work skills through both my front line work and my clinical consultations. Having the opportunity to engage with clients both in hospital and in the community provided me with a well-rounded experience of older adult mental health supports and the struggles of providing this support within a fragmented system. The next chapter provides a critical review of my practicum experience and explores my critical approach to practice and my use of self to gain a better understanding of its relevance to my social work journey.

Chapter 4 - Reflection

Overview

The following chapter details a critical reflection of my journey during my practicum following Fook's (2004) critically reflective process. It details my initial curiosity for working with this population as well as exploring the concepts of critical reflection and the use of self. I will deconstruct the initial thoughts/assumptions I held personally and professionally based on my own social and educational foundation. The chapter will then identify profound and challenging events that occurred during my practicum and how these same occurrences in turn impacted my practice. The chapter will reflect how the experiences I had were influenced by Ministry of Health and Long Term Care system and how social work can help to address these barriers. Lastly, this chapter will look at the reconstruction of my views following my practicum on my use of self and of my personal social work practice modalities

Initial Curiosity of Population

My initial curiosity and drive for working with the older adult population came from my grandparents. Raised by a single mother, I spent a fair bit of time with my maternal grandparents. This led to a strong bond, and a connection with an older generation that has continued throughout my life. Much of my time with my grandparents centred on listening to music and discussing popular culture and personal experiences from their early adulthood. I soon realized that I genuinely enjoyed the company of older adults in general and could engage with them on topics which they were familiar, due to the exposure provided to me by my grandparents.

My capability and passion of interacting with older adults was reinforced during the completion of my Social Service Worker Diploma during which time I was hired at a Long-Term Care facility. I continued to work there as well as gaining employment with a community based

agency which assisted older adults within their homes during my undergraduate degree. I began to gain alternative perspectives and appreciation of the structural systems at play for older adults in need of assisted living. This gave me a different view of older adult issues within a long term care setting, as well as the barriers that those who are living in the community face in terms of accessing supports.

During the course of my post-secondary academic journey my grandmother was diagnosed with vascular dementia. Although I had, had the opportunity to work with people that were living in Long-Term Care (LTC) with a dementia diagnosis, the interaction and support that I was able to offer was very tertiary. In LTC the bulk of support that was offered was based in medicine and occupational therapy. In contrast, those I was able to directly support in the community were either newly diagnosed with dementia, if they had cognitive impairment at all. As a result, I was able to gain insight as to some of the difficulty those living with this diagnosis faced in finding adequate, affordable support in the community.

Despite my first-hand knowledge through the involvement with my grandmother, I wanted to learn more about the disease of dementia itself. My goal was to gain a better understanding of what dementia was and the implications it had on the life of the person living with the diagnosis, as well as the experiences of their families. My hope was that through exploring these aspects of the disease outside of my own experience, I would be able to gain a better understanding of what supports were commonly needed. I began to take the knowledge I had already acquired both academically and through my direct practice with older adults and expand it by looking at generalized aging research. I completed additional gerontology courses to earn my certificate in gerontology along with my bachelor of social work degree in the hopes of gaining a better understanding of the challenges that older adults face.

Once I was admitted to the Master of Social Work program I had the ability to integrate my interests of gerontology and social work in a formal academic setting. Although there was literature about gerontological social work available, much of the literature was not Canadian based, and that which was Canadian was often outdated. I continue to see these gaps in literature as an area that requires focus going forward within social work.

A Critically Reflective Approach to Practice

Throughout my academic journey, I have been able to review various forms of critical reflection through innumerable literary sources. My practice in the community has also provided me the opportunity to apply some of the aspects of reflection to my practice. However, given the lack of social work specific supervision in these positions, I have often felt I was merely reviewing my practice on a superficial level. It was in learning about the critical aspect of self-reflection through the course of my master of social work degree that first intrigued me in exploring a critically reflective approach to practice. I realized that I have never had the opportunity to thoroughly examine the way my own subjective journey has influenced my practice, more specifically my practice with older adults. This made me begin to question my practical abilities as a social worker. Having been in an academic setting for so many years, I worried that I would not be able to effectively translate the skills I had acquired into a practice setting successfully.

In light of this, I began to discuss my feelings and fears with my colleagues and mentors. It was during this process that I was directed to explore the critical reflective approach to practice and to examine my use of self. I began to research these topics, and found that the more literature I consumed, the more I could appreciate the value in the process. I began to see that reflecting on my practice was not a punitive exercise but could enhance my interactions with clients. In

consultation with my peers, some colleagues felt that they were able to remain objective and felt that subjectivity was not ‘professional’ in practice. I began to notice subtleties of subjective practice differences amongst myself and my colleagues. This in turn encouraged me to explore further the intricacies of subjective practice, the practitioner’s use of self and its place within the vocation of social work. Immersing myself in the literature and practice of examining the self through critical reflection is the best way to explore my own thoughts about social work as a vocation. This has caused me to challenge my own beliefs, feelings, and approaches, and my power within practice.

This approach to practice is transferable amongst various populations and agencies. I have come to learn that critical reflection is something that is not initially easy to practice, but over time, and with diligence, offers an ethically sound and effective means of support and understanding of self. Engaging in the critical reflection process throughout the course of my practicum helps to put many things into perspective both personally and in practice, which will be discussed in detail below. Critical reflection and exploring the use of self, provides me the opportunity to challenge my thought processes and the processes of those around me during my practicum in an open manner. I believe that the practice environment of a medical setting with older adults living with dementia, offered me the opportunity to explore these topics within an environment that was challenging with a population that I was passionate about.

Initial Thoughts and Assumptions of Practice and Person

When I came to the end of my MSW course work and was preparing to begin my practicum at Grey Bruce Health Services (GBHS), I found myself struggling with self-doubt about my abilities as a social work practitioner. I was plagued by thoughts and beliefs that I was perhaps more adept at being an academic than a social work practitioner. I believe this came, in

part, from my longstanding academic career and my inexperience working within a medical setting. Holding these thoughts and beliefs about my own abilities in turn caused some trepidation about my interest in exploring my own practice skills and abilities through critical reflection. Given the enigmatic nature of critical reflection, it can create a sense of uncertainty for practitioners who are challenged to problematize their own social work practices (Trevelyan, Crath, & Chambon, 2014). Although I wanted to explore my practice abilities in detail, I felt anxious that what I found out about my capabilities as a social worker would be found wanting. Ruch (2002), as well as Fook and Gardner (2007) reported that it is these feelings of anxiety that often act as a barrier which prevents social workers from engaging in critically reflective practice. In challenging the feelings of fear and doubt, I began to wonder if the belief that objectivity is attainable within practice and the notion of a 'professional' approach to social work, were underlying much of my inner dialogue. Corey (2012) prompted that it is through critical reflection that this inner dialogue be explored and challenged. This provides the practitioner the opportunity to have their feelings examined as the 'other' (Miehls & Moffatt, 2000). I now realize, through immersing myself in the literature on critical reflection, that the feelings of anxiety I was experiencing were not isolated to my own journey within social work.

The belief that social workers must be 'professional' and objective is fostered and permeated within academic and practice settings. This was largely reinforced by various literary sources, agency policies, as well as the professional colleges. I am not contesting the need to engage in ethical and effective practice relationships that insure one is working with the best interest of the client. Rather, it is the belief that an individual can separate their personal self and the experiences therein from their social work practice. Dewane (2005) indicates this to be fraught with inconsistency. Knowledge, language, power, and identity are all aspects of a fully

realized person that should not, and I postulate cannot, be compartmentalized when ethically engaging in a helping relationship. To frame these aforementioned aspects within intersectional considerations, further highlights this impossibility. Being raised as a female in a small, rural, Anglo-saxon community with a strong Catholic faith base, by a single mother, within a neo-liberalist society, it is naïve to think that these foundations have in no way influenced how I interpret the world around me. Though I agree it is important to be aware of biases and triggers within practice, these are not simply addressed by naming them; it requires constant awareness and exploration of the actions or inactions on behalf of the social worker to engage in truly ethical practice (Trevelyan, Crath, & Chambon, 2014).

By reflecting on my own personal interactions with clients and by highlighting moments where I had responded in ways that may have caused harm to my clients, I am able to offer ethical and effective support on a broader scale. This is often experienced as social workers value things like anti-oppressive practice, social justice, and the empowerment of clients. Those who examine their own practice critically, and see areas of bias, oppression or missed opportunities to promote social justice can cause social workers to question their role and even their vocation (Trevelyan, Crath, & Chambon, 2014; Fook, 2012). Throughout the course of my practicum I found that I struggled with many of these same issues. In accordance with the critical approach to practice, I first felt it important to explore my own personal thoughts and biases about the topics of knowledge, personal power, touch, and identity prior to my practicum experience to develop a baseline.

Dementia in a Different Setting

Though I had incorporated the study of dementia into much of my academic career as a specialized area of interest, I was limited in terms of my practical experience with case

management opportunities of older adults living with this disease. Through my experiences with my grandmother and support opportunities within the community, I believed I had an understanding of dementia and the trajectory of the disease. Although I knew there were many forms of dementia, it was apparent in my practicum that I had only been exposed to a small variety. I realized that I had no comprehension for the myriad of more specific dementia diagnoses and how each would present in practice. I was not aware of any behavioural components that I came to realize, were a large aspect of the disease progression. These were not factors with which I had, had the opportunity to work with prior to this practicum.

In my prior practice experience, when a social worker was involved with a client living with dementia, the goal of practice was to act as a guide to resources for the family/caregivers. The bulk of my prior work in geriatric social support was conducted within the areas of Orillia and Barrie, Ontario. While the social work skills were transferrable, the ability to connect clients and their families with relevant resources within an urban setting is very different than in a rural setting. There were aspects of providing care that I had never had to consider before such as long distance travel, social isolation, and insufficient resources to name a few. Without a broad exposure to all the resources available in the Grey and Bruce area I struggled to gain a sufficient foundation of resources that I could bring with me to GBHS. This again reaffirmed for me the different skills and knowledge base that social workers need to possess, and how impactful things like environment can be.

Knowledge

Prior to beginning my social work educational journey I, like many others, conscribed to the belief that imperial knowledge was the only form of credible knowledge. The hierarchy of knowledge places the highest value on technical or scientific knowledge, and knowledge

founded through intellect (Fook & Askeland, 2007). This was reinforced socially as trust and authority was often given to those in positions of power built on quantitative knowledge; such as doctors, lawyers etc. It was through social work academia that I was introduced to more qualitative forms of knowledge. I came to find that my thought process closely aligned with a postmodernist framework (Lee, Sammon, & Dumbrill, 2006). Within a postmodern framework, many types of thinking can be legitimized (Fook & Gardner 2007). In this view, practical knowledge is valued just as much as traditional knowledge. Fook and Gardner (2007) affirm that this framework takes into consideration the context in which knowledge is generated and interpreted, while highlighting that all forms of interpretation are imperfect. Poststructuralism, postmodernism, and critical theories are the overarching theoretical underpinnings for critical practice in social work (Fook, 2012; Fook & Gardner, 2007).

Coming from the post-modern perspective, I felt some trepidation about my placement within a hospital setting. I assumed that the social workers within this setting aligned with the traditional values of knowledge; and if they did not, that those within the nursing profession did. I am connected both personally and professionally to various individuals within the nursing field; who historically have placed the value of medical health over that of mental health. Again I find this to be a belief that is subscribed to socially within Western society. I realized that it was my interactions with nursing professionals that caused me to place this unfounded narrative on those within my practicum setting. Having come from an academic setting wherein those around me held similar values on the importance and effective role of qualitative knowledge, I became apprehensive of what it would mean to enter this different environment. Would there be knowledge sharing amongst staff? Would each profession be a silo unto itself? It was as a result of these questions that I began to explore my own practice methods.

I believed that mental health was and should be considered a separate issue from medical health. For me, making this demarcation came from my lack of knowledge of medical social work and the feelings of anxiety that this in turn provoked. Having a practical, community based knowledge of geriatrics and mental health services, naturally I gravitated towards the familiar and the comfortable. I soon came to find out through the critical reflective approach to practice that I would be spending my practicum in discomfort, challenging both myself and my environment in terms of what I thought I knew and what I had yet to learn.

Personal Power

For a number of years, I equated earning a degree with becoming a 'professional' within the field of social work. I realized that I placed a lot of emphasis and power on social work as a 'profession'. In reflection, I believe that this came in part, from my foundation of the social need to be seen as a 'working professional' as is often encouraged within our capitalist, consumer based culture in Canada (Mahon, 2008). I was working toward my social service worker diploma when I came to observe that there were distinct differentiations within the field of social work. I saw this distinction between a social service worker and a social worker. Though reflected in terms of critical thinking abilities and theoretical knowledge base, it appeared to me that the higher the level of education achieved the more credibility of the individual would be given in relation to their abilities. I too believed that the higher the level of education you received spoke to your competency, and ability to practice ethical social work. As someone who has felt an internal pull toward this type of work; being seen as competent and engaging in ethical practice were aspects that I valued highly. In hindsight I believe this may have been the driving force behind my pursuing this degree, leading me to this practicum experience.

The Power of Touch

I have detailed previously in this document the general power differential between social workers and their clients. When I reflect on this in relation to my practicum, one area stood out as a large area of trepidation for me. This was in relation to touch. The Ontario College of Social Workers and Social Service Workers Code of Ethics (2008) summarized many of the areas with which social workers' needed to be cognisant and caution in exercising their power within the interpersonal relationship with their client. One such area of power is touch. According to the OCSWSSW Code of Ethics (2008) touch is described as the following:

“Touching: Touching, as included in Principle VIII: Sexual Misconduct, is defined as physical contact of a sexual nature. It includes hugging, holding, patting, stroking, rubbing and any form of contact which is unnecessary to the helping process” (p.45).

It was in light of this that I was historically hesitant to engage in touch with clients; primarily for the fear that any touch would be misconstrued to have ill intent. Throughout the entirety of my social work academic journey, the message has been fear based in terms of engaging in touch with a client. Being aware of my position of power within the interpersonal relationship could in turn cause the client to feel pressured to engage in; in honesty it was born out of self-preservation of my social work practice.

Identity, Use of Self and Consultation

The use of self is a topical subject within social work literature as a whole, with substantial roots in supervision literature focussing on transference, countertransference, and self-awareness (Chapman, et al., 2003; Knox & Hill, 2003). Mandell (2007) argues that examining and understanding the use of self within social work should be considered as an intrinsically essential component of practice, because it begins to reframe the focus from an

individualistic stance to a more relational one. Understanding the complexity and fluid nature of the self poses important implications for critical social work practice, particularly when examining the identities of social work practitioners (Fook, 2012). This makes it clear that social workers are not infallible, rather, through recognizing and being transparent about their humanity, their humility, and their emotions they are relatable to their clients, and more authentic to their self-narrative.

In reflecting on this further, I feel that the drive to be seen as a competent and contributive social worker extended beyond the field of social work itself. I began to take the concept of validating social work as a profession and putting it in the context of my practicum. I worried that within a medical setting like the hospital, that the role of a social worker would be diminished in comparison to more medically based roles. It is reported, that often within a multidisciplinary team, especially within a medical setting, that the importance of social work is often diminished (Turner, 2011). This made me nervous about how clients and their families would in turn feel about my practice. I realized that I was entering my practicum with the goal of validating social work to the clients and their supports as well as other more socially established professions. I was struggling to shift social work from a 'profession' to engaging in social work as a 'practice', and have that be equally as effective within a medical setting. Yorke, Grant, & Csiernik (2016) contended that supervision is the only way to truly examine the self, the aim of which is to become aware and in tune with the self, in all of its subjectivity, in an effort to understand how this lens affects the self and its interactions with others.

As I detailed within the learning goals section of this document, I have never had the opportunity to receive feedback from a fellow social worker in previous consultative settings. Although this has offered me the opportunity to have my practice reviewed through a variety of

professional lenses, it is an area for me that I have found wanting. Likewise, I have never had the opportunity to formally engage in consultation with my peers under a critical framework.

Though tentative about the process itself, I was hopeful that engaging in social work specific consultation within my own wheelhouse will be beneficial in aiding my work with clients as well as allowing me to have a better awareness of self.

Pre-Practicum Stage of Reflection

Having limited consultation in the past is not to say that I was not fortunate in being supported by highly capable and inspiring individuals; there was simply the element of a social work lens that was missing. I had no real concept as to how this impacted my ability to reflect on my practice. It was not until I began to explore the role that consultation plays within the critically reflective approach that I began to see what I was missing in terms of my own reflective practices. Consultation within the critical approach helps transform practice, to encompass more empowering, ethical and effective experiences for both the practitioner and the participants by providing a safe space to debrief the events surrounding practice (Marlowe et al., 2015).

Preceding this exploration of the critical reflection approach to practice, I feel that my process best aligned with Kondrat's (1999) definition of reflection. I was able to explore my actions, thoughts, beliefs, and assumptions, and correlate these various aspects of self to my practice (Kondrat, 1999). I felt I was engaging in an in-depth reflection of self. However, in reviewing the literature of the critical approach to practice, I came to realize that there were aspects of my practice and self that I had not considered which were impacting my approach, which I have offered as examples above.

Challenging My Practice

Critical reflection involves the practitioner examining them self and understanding how their personal history (historical, social, political views, and upbringing) influence their beliefs, opinions, and actions when working with a client (Fook, 2012). From there, the practitioner must constantly reflect on their practice and challenge themselves on their actions and beliefs in relation to power, knowledge, language, and identity and how these areas impact the therapeutic relationship with clients (Fook, 2012). Once these areas have been fully examined it is then up to the practitioner to acknowledge these areas and engage in practice accordingly to avoid doing harm to the client. Critical social work therefore seeks to acknowledge issues of oppression and promote inclusivity. It seeks to do this by viewing issues through a multifaceted lens that incorporates: race, gender, sexual orientation, ability, knowledge, power, identity, and language; a sharp contrast to objectivity in practice. Throughout the course of my practicum I was faced with a number of events that challenged my social work practice. Having detailed my initial thoughts and assumptions about my practicum experience prior to its commencement, I will now go on to highlight the various ways in which these assumptions were challenged.

Pre-Structured Power Imbalances: Social Work and Clients

In addition to highlighting the power and privileges that the team as a whole has held in relation to the assessment of clients; I was also able to gain a clearer picture of the inherent power I had over the clients I worked with. Webb (2000) highlighted four areas wherein social workers hold pre-structured power over their clients: 1) theoretical knowledge bases including competences and education in a variety of social respected subjects including psychology, sociology, policy, and advocacy. 2) Legal power (usually involved in risk assessment) that can influence rights/abilities being supported or removed from an individual if there is a suspicion of

harm to oneself or another. 3) Respect based on their elocution and education as credence in given in society to those who have obtained a standard of education and are able to conduct themselves within various environments that are mutually respected based on knowledge of language and ability. Lastly, 4) the title of ‘professional’, and the recognition of status and power that comes with this title, in order to legitimize the profession and the role as a social worker. It is within these areas that Webb (2000) argued that social workers host “pre-structured power” (p.3) and subsequently must give great attention to these areas to ensure that abuse of this power can be mediated.

Included in these four areas were areas that I had never framed to be positions of power. I quickly began to see areas within my practice where these power imbalances were visible. First, I feel that pre-structured power of theoretical knowledge, advocacy, and ability are synonymous. I had never problematized the knowledge-based role of advocacy before. It was once I began to work with the families of individuals who were newly diagnosed with dementia in hospital and the community that I was able to appreciate how influential that knowledge is. It was often up to the social worker in both the in-patient and out-patient settings to connect with families and caregivers. Sometimes this was to complete some psychoeducational teaching about dementia, or ways to address behaviours. Other times I acted as a conduit to community based resources which could act as additional supports to the client and their care providers. It was in reflecting on how this knowledge of community resources as well as the larger Long-Term Care system that really impacted how I approached these topics with clients. I began to appreciate how difficult it must be to be placing the care of yourself or a loved one in the hands of a stranger simply because they are more familiar with a system, or no longer able to provide the care themselves. It was during these conversations with families and clients that I was aware of the

fact that the individuals I was supporting, both client and family, were older than me. As a young woman in my late twenties, I worked hard within my role to be taken seriously, and to be clear that I was competent in my skills and ability to advocate for the clients' care. As well I needed to insure that I was able to get a comprehensive understanding of their needs in order to make appropriate referrals.

This was an ongoing topic of reflective discussion with my peers as well as my supervisor. We discussed how difficult being a social worker who is a younger adult, especially in relation to age specific issues that older adults and their families face, can be. Much of my struggle came with not trying to come across as a 'professional' but as a practitioner. I continued to challenge the power that my role in their care provided to me. I became more diligent at making sure I was advocating alongside my clients and their family members. I was able to build rapport with my clients and empathize about the difficulties and frustrations of navigating the Long-Term and geriatric community care systems.

Likewise, I had to be mindful of my language and topics of discussion when supporting clients. Language, discourse, and narratives are heavily laden with power. The ways in which knowledge, stories, and beliefs are communicated are just as important as how they are generated and interpreted (Fook, 2012). As such, it is of equal importance that language is critically examined. As time went on in my practicum, I came to find that the ability to translate concepts associated with geriatric mental health into more accessible language was an asset to my practice. I often had to make sure that how I was communicating these concepts was not seen as punitive, negative, or suggestive. I would often include a blanket statement at the beginning and end of my appointments indicating the importance for family to understand what I am saying should they need to be informed for any decisions they may need to make. I would make sure to

ask if they had any questions and then provide them with my contact information at the hospital should they have questions after I had gone. I found this to be easier to do in the out-patient settings.

On the in-patient unit I found myself slipping into the dominant language patterns of the hospital setting at times. My use of language and relaying accessible knowledge was an area of my practice that I continued to challenge myself on throughout the duration of my practicum. I became more aware of acting as a translator for patients and their supports to ensure that they understood the medically laden language used within the hospital setting.

Next, in relation to legal power, I have discussed at some length throughout my learning goals chapter the noticeable power variances that social work as well as other roles on the in-patient assessment unit possesses. By the time that many of the clients arrive for an assessment on the unit they have progressed to mild or moderate stages of dementia. First, the fact that they are admitted to a hospital to be assessed is an exertion of power. They are on a locked unit, although it is to prevent them from wandering into unsafe situations, it is still a dominant encroachment on the clients' independence. Clients are often taken from their home where they are surrounded by loved ones and placed into an unfamiliar, sterile situation with strangers. There is an inherent nature for the care of the unit to be intrusive as part of the assessment is to see what tasks clients can perform independently including showering and getting dressed. Although these are not aspects of the specific assessments I performed; they all have strong implications to the overall assessment clients received. In addition to this, during the course of the assessment, clients often have rights taken away (ability to manage finances, whether they can go home or not, driver's license etc.).

As the social worker on the unit I had to connect with the family members and support staff to gain collateral information about the client. This too was an exertion of power, as we were able to gain intimate details about a client's life from outside sources. As I was a part of the team performing the assessment on the client, I was legally allowed to ask their next of kin for information about them. Although this is done to get pertinent information about the client to gain a baseline for behaviours and abilities, it is still invasive. Much of my reflection in relation to this aspect of my practicum was spent speaking with my supervisor about the need to be critical of the information we were being given by others. I had to remain cautious. Just as my experiences were not free from a subjective lens, neither were the views or opinions of the families providing me information. My supervisor and I would often conduct collateral intakes together via the phone. After each call we would take the time to reflect about the call and determine any possible family dynamics which could be at play and influencing the information. This helped us to not only learn more about the client's familial situation, but to also engage in reflexivity while in practice scenarios with family.

Challenging these areas of pre-structured power imbalances came from my subjective, political views of social liberalism; believing that the larger systemic framework should be more inclusive and supportive of the public in which it serves (Mahon, 2008). In addition to this lens, I was also reflective of my feminist approach to practice. As mentioned, a result of my upbringing, I find my practice philosophy is strongly aligned with the feminist perspective; seeking equality to access for all regardless of gender, age, or ability. I feel that in my practicum setting these views were relatable to the caregivers and clients which in turn helped to build rapport within the therapeutic relationships. It also highlighted future areas for advocacy working with the geriatric demographic.

Valentich's work (2010) highlights the premise that socio-cultural foundations are important to acknowledge when engaging in reflexive professional practice. The myriad of theories, frameworks, and modalities which I most commonly draw from include but are not limited to: feminist, political economy, strengths-based, and anti-oppressive practice (Walsh, 2010; Turner, 2011; Hooyman & Kiyak, 2011). Each of these perspectives are reflective of my passion to combat structural oppression, but also to effectively advocate, and support people in and out of their communities with a sound theoretical and practical knowledge base. Of these, my strongest views are held within feminist approach to practice. Despite being the foundation of my practice, it was important to be reflexive of the implications that these modalities had within my practicum.

I found it challenging at times to remain hypervigilant to keep my personal views from influencing the care decisions of the client or their family. There were subtleties within my practice that I was made aware of by my supervisor, which highlighted my subjective beliefs. One example of this was noticed as I presented future care options to clients and families. I led with the state supported options before exploring private care options. I believe this to come from my social liberal perspective in terms of geriatric care. To address this, I began to have conversations with families prior to offering the information to assess if they were interested in state supports or if they wished for private care options.

It is in recognising these various areas and opportunities for power that social workers have the responsibility to be aware of and challenge pre-structured power imbalances within society, research, and within their own therapeutic relationships. Scholars have noted that critical reflection holds a prominent place in building theory, especially within the power relationships between social workers and the clients they work with (Daley, 2010; Fook & Gardner, 2007).

One way to examine this power is to understand where the concepts for these shifting power dynamics come from and how they can be influenced and perpetuated by both participants and practitioners.

Reflecting on the Power of Touch

As I had detailed previously, prior to commencing my practicum at GBHS I had reservations about the notion of touch in relation to my work with older adults. In contrast to this, were various approaches specific to working with older adults living with dementia; which would promote the inclusion of touch within practice. A recent Cochrane report conducted on massage and touch for dementia found that touch was in fact effective and a supported tool to use when working with those living with dementia; particularly when addressing responsive behaviours (The Cochran Collaboration, 2008). Offering a hand or arm for support were not gestures that I was conscious of before; nor did I associate it with power within the therapeutic relationship. It was not until I was able to critically reflect on my practice that I began to understand my own notions of touch and to challenge my fear-based reservations. I was forced to reflect on my actions and to problematize touch. Was I engaging in touch in support of the client or was I engaging in touch for my own need? Similarly, was I refraining from touch for personal reasons, even if it was therapeutic for the client?

Although with the out-patient team there was no cause for touch beyond a handshake, on the in-patient unit the opportunity for engaging in touch with a client was widespread. Often times while on the unit, clients would come up to you and take your hand or arm and start to walk with you. On occasion clients would hug or dance with you. Conversely, clients could also become physically aggressive. It was because of this uncertain reaction of touch that being aware of non-verbal cues and body language became very important while working on the unit. I was

initially very hesitant to interact with clients through touch. However, through continual clinical consultation reflections I began to problematize negating touch in practice with older adults.

Though I was careful not to initiate touch with another, by allowing them to approach me I hoped to demonstrate respect for their autonomy. Over time I was able to explore the meaning behind much of the physical interactions clients had with staff on the unit.

Though in many cases touch was a result of care being provided, at times touch was also a conduit for empathy and affection. As I write affection, I am also aware of the contextual image that affection conjures through language. As a person with a dementia diagnosis progresses in their disease, spoken language loses meaning. Eventually the individual is no longer able to communicate their needs or wants verbally. For many of these individuals, touch becomes their way of expressing themselves. To refuse touch that is for the benefit of the patient is similar to ignoring them if they were speaking to you. In addition to this transition of communication; many of these individuals arrive at the unit having left their family homes where they have lived for years, often with a spouse. Being admitted to the in-patient unit alone, knowing no one can be very distressing at this time. I both witnessed and experienced the role touch could play in these scenarios. Without any barriers of 'professional preservation', I began to walk with clients and hold their hands, or dance with them. So long as I was comfortable with the interaction, it became more about what the client wanted or needed than about my fears. As time went on, I saw how this impacted the relationships I was able to have with clients. Though their cognitive function may not be able to remember me, they were able to remember that they loved to dance or that they liked to walk with another person; in the end it provided some level of comfort to them during their assessment and demonstrated empathy.

Challenging Knowledge through Education

Throughout the course of my practicum, in addition to the direct practice experience I was able to gain, I also had the opportunity to attend various multidisciplinary training opportunities that were specific to older adults. These trainings included a two day training seminar on elder abuse in the community, sponsored by the group Ontario Network for Prevention of Elder Abuse (ONPEA). I was also able to attend Gentle Persuasion Approach (GPA) for dementia care training, provided by the Alzheimer's Society. Although these two training sessions dealt with varying subject matter, the underlying theme that I noticed within each was the presence of social work values and principles and how they were being taught to those attending the workshops. More specifically, these principles included person-in-environment perspective and the strengths based perspective. Social workers strive to bring a person-centred approach/perspective to a multidisciplinary team (Abendstern et al., 2014). Although sharing this knowledge is important, as it expands the skills of those who are working with older adults and adds to their competencies, it also caused me to pause and reflect on what these trainings meant to me.

As the only social worker present at either training, what I came to find was that the material seemed to simplify the skills and at times philosophies or theories that social workers have cultivated. In turn these trainings were delivered in a way that was more understandable for all involved. I had two initial reactions to this. I worried that these trainings were presenting these concepts as an "easy task" which could really blur the role of social work, especially within the medical setting. I feared that this would perpetuate the mindset that social work was not a validated role in geriatric support. Through my journaling I worked to reframe this concern. What would be so wrong to have various social work approaches translated to more individuals

in a way that was approachable and transparent? I continued to challenge my thought process of social work as a “profession” as opposed to a “practice” without even realizing that this was a permeable thought. If in the end, these trainings worked to inspire empathy and the inclusion of a broadened perspective when working with older adults; is that not also my goal?

Although I cannot say that I was able to learn a lot of new material from the trainings themselves, I can say with gratitude that I was able to learn from the other individuals who attended and participated in the trainings. Being entrenched in social work literature and theory for so many years, I took for granted some of the knowledge, language, and concepts I use. Through these training opportunities I was able to see what questions my clients may also have about the language and concepts surrounding older adult care. This has in turn helped me to reframe how I engage not only with colleagues from various academic backgrounds but also with clients, and in the case of cognitively impaired older adults, their families as well.

Provoking Emotions and Responses

During my time with both the in-patient and out-patient geriatric teams I felt a range of emotion in varying degrees which were often sparked by my interactions with patients/clients or family supports. The most permeable emotion that I first documented in my journal was fear. Having been a student for so many years; the thought of coming to the precipice of my time with academia and transitioning into a practice setting full-time caused me to face a lot of self-doubt that I have not experienced before. There is an intense sense of anxiety, fear, and embarrassment surrounding the self-disclosure, of mistakes or growth opportunities for fear of reprimand. Within these contexts the format of asking critical reflection questions can cause the practitioner to feel vulnerable, especially if critically debriefing with peers (Fook & Askeland, 2007). To examine their own practice critically, and see areas of bias, oppression or missed opportunities to

promote social justice can be difficult to understand, and cause social workers to question their role and even their profession (Trevelyan, Crath, & Chambon, 2014; Fook, 2012). Miehl and Moffatt (2000) argue that it is in this anxiety that practitioners are best able to relate to the 'other' and develop their identity as a practitioner through various imaginative possibilities. I found that using the anxiety I was feeling spurred my insight during my practicum to deepen the level of reflection I was able to engage in with myself and with others.

In addition to fear, I also experienced feelings of contempt and anger throughout other occurrences within my practicum. Though I am not proud of it, I felt contempt with some of the clients that I had no choice but to support. This was profoundly more difficult to keep cognisant of than I had originally thought. Many times I was supporting an older client who had been convicted of sexual crimes against children as well as other members of their families. In addition to this there were times I was supporting a client that had a history of or was currently living with, alcohol addiction. From previous work experience and self-exploration, I know addictions to be an area that triggers me and that I cannot work in. This is largely based in familial struggles with alcohol and illicit substance abuse. Being cognisant of this, it is an area of support I have thus far been able to avoid. However, with only one social worker to support the in-patient unit; I was forced to work individuals facing these struggles. This is something that I am aware of, and continue to work to unpack in both my personal and professional life.

The difficulty of offering support for the individuals on the unit increased for me as by the time I was supporting them, I was seeing them in the mild to moderate stages of dementia. These individuals ranged from having little recollection of their previous offences to having regressed to the time in their life where these compulsions were active. I found that on the in-patient unit that some of these individuals would engage in targeting behaviours of other

vulnerable persons, this included trying to engage in sexual acts with persons who could not give consent. Being aware of this caused all me to be hypervigilant when meeting with these clients to insure my safety as well as the safety of other patients on the unit. It was the emotional response of contempt that initially led me to experience a strong sense of anger and frustration in my role as a practitioner. Why could I not control my feelings of contempt for the patients I was serving?

Throughout my years of education it was constantly enforced that we have to watch for our biases and ‘check them at the door’ when working with clients. I came to see the belief that social work can be objective promotes an unrealistic standard of practice. In order to address these strong emotions of anger, and to the best of my ability minimize them negatively impacting my work with these clients, I began to have informal consultations with my supervisor on a more frequent basis. We often spoke about what I was feeling and in what ways this could in turn harm the patient. We also spoke about the patient’s perspective of the situation; which helped me to gain some much needed insight to their current situation and helped to remove my focus from their past. Initially, I asked that my supervisor go so far as to review my charting on these patients to insure that I was not allowing the negative reactions to influence my documentation or augment my perceptions of the actions/behaviours I was observing. I came to find that it was the clients that challenged me the most in terms of emotional response and personal bias that taught me the most about the important role the critical reflective approach plays in social work.

Once the fear had passed, and I was able to effectively address the feelings of contempt and anger I experienced, I was elated to feel a strong sense of enjoyment that came from the work I was able to do with these clients. As someone who has seen the journey that those with dementia face personally and professionally, I can attest that it is not an easy diagnosis to live with for the client or the family. I found that it was in having this awareness that I was able to

appreciate the little things a lot more. Watching a glimmer of recognition crossing the face of a patient often meant so much more to me than any responsive behaviours that were brought exhibited. Talking to clients about their hobbies and family, or just sitting with them to be there fostered such a strong sense of privilege for me. Being immersed in an environment where there are so many negative outcomes for so many, it fosters a focus on strength for the clients, family and staff. In the end, it was the combination of all of these emotions, through the course of my experiences that I was able to gain profound insight of self during my time with GBHS.

Challenging Bias and Missed Opportunities

Of all of the experiences I was fortunate enough to share with clients during the course of my practicum at GBHS, one encounter had a profound influence on my practice. It is in response to this that I wish to offer the following situation to demonstrate how critical reflection was impactful in my practice.

An older client I supported during my placement was being assessed on the in-patient psychogeriatric unit following an incident at home which questioned this client's ability to thrive in the community. It was discovered that this client was the caregiver for their spouse who was in the advanced stages of dementia. The client's spouse was found to be suffering from malnutrition and suspected neglect at the time that the client was brought into the hospital. The client's reason for presenting at the hospital was due to the fact they had been found unresponsive; the result of substance abuse. The spouse with dementia was remanded into care and given an emergency long term care placement at the request of the children. This client spent a number of weeks in the hospital in critical care. As time passed this client was able to regain their faculties. Following an assessment on the in-patient unit, this client was found capable of making their own care decisions and wished to go home after retrieving their spouse from care.

Unfortunately, the client had been evicted; the result of many months of unpaid rent and could not return home. Finding housing and transitioning this client back to the community then became part of my role as the social worker on the unit.

The reason this client had such a profound impact on me was because of the emotional response that was evoked in me and how this in turn influenced my practice. There were a few aspects about this specific case where my subjectivity drove my practice responses. First, as I have mentioned, alcohol and addiction is an area that I am aware is a trigger for me. Having this awareness prior to working with this client was helpful in the early stages of providing support. In addition to general journal entries about my practicum in a broader sense, while providing care for this client, I often had to make critical reflection entries that were specific to them. What I found throughout re-reading these entries was that at times I identified this client by the addiction rather than the person. With their intentions often rooted in social justice, social workers must be wary of creating identities for clients (e.g. as victim, or person needing empowerment), just because the individual is receiving support from a social worker (Fook & Askeland, 2007). I was using my power in reflection to promote skewed language and force an identity on the client which perpetuated a negative social discourse for this client. This helped to continuously reaffirm for me my subjective stance on alcohol abuse and addiction while working with this client, and to be reflexive during my practice of how I was responding to them. When working with them, I offered many rehabilitation opportunities to this client which were all declined. In reflecting back on the situation I came to realize I never engaged in any harm reduction conversations with this client. I simply took for granted that there was no desire to change, although that may have been true, it was my assumption of this based on my personal experiences that was the driving force behind my lack of pursuance.

In addition to the substance abuse issues, the fact that this client wanted to retrieve their spouse and resume living in the community was difficult for me. Knowing that this client's spouse had suffered neglect as a result of the client's addiction issues caused me to feel protective of the spouse and cast judgement on the client. In the end, it was not possible for the client to resume living at home with their spouse given the insufficient care that could be offered in the home. Even though this impacted my client greatly, I felt a sense of relief that the spouse would be safe and continue to be cared for adequately.

In the end, there were issues of bias and missed opportunities for social justice with this client, which were driven by my subjective world view. I had a lot of consultation surrounding this with my placement supervisor as well as my peers. Engaging in this reflection were some of the most difficult conversations that I had through consultation. I really had to embrace the ways in which I had failed this client and had caused harm.

Through the feelings of discomfort, I was able to make several realizations of areas that I had missed the opportunity to offer support. To examine their own practice critically, and see areas of bias, oppression or missed opportunities to promote social justice can be difficult to understand, and cause social workers to question their role and even their profession (Trevelyan, Crath, & Chambon, 2014; Fook, 2012). I came to realize that this client had the right to live with the risks they were living with; and I still had the obligation to provide them with all of their options, and to not assume what is most appropriate. I had pre-structured power surrounding knowledge of resources that I should have shared so that the client was making informed decisions about their options. The spouse of this client was not my client, and I found my focus shifting to protect my client's spouse as opposed to supporting my client. This response I believe to be fuelled in part from my concern for the wellbeing of the spouse. More than that, I feel that

my passion for older adults with dementia and my subjective views of support for them came to the fore. It is not for me to judge the situations within my clients' lives. What is more, through this judgement I lost focus on who my client was. I did not support my client to the fullest extent of my ability, therefore engaging in practice that was not ethically sound.

I have found this to have impacted my reflection process greatly, as well as my view of self. I was surprised how easily the subjective self can be present without the practitioner's awareness. Once I had realized the areas of my practice which had caused harm, I questioned my abilities as an ethical social worker. Eventually through consultation with my supervisor and peers, I was able to process that I had not intentionally caused harm to this client, and it is in this increased awareness of self that I can continue to challenge and enhance my practice going forward. To address these areas of my practice I ask myself if I have offered every available resource to the person I remind myself of who my client is and what my role is. This coupled with the many other facets of the critically reflective approach to practice have enhanced how I will continue to engage in social work practice.

Clinical Consultation and Response to Practice

Critical reflection calls for consultation to support the practitioner on their journey and to normalize feelings of anxiety and concern (Ganzer, 2007). Consultation within the critical approach helps transform practice, to encompass more empowering, ethical and effective experiences for both the practitioner and the participants. This is done by allowing the practitioner a safe space to debrief events surrounding practice (Marlowe et al., 2015). While engaging in practice on the in-patient unit I was able to meet bi-weekly with my supervisor, to explore my practice skills. I felt comfortable disclosing concerns I had about my own practice and gathering feedback from her. She was very proactive in ensuring that I was able to work

towards and through the goals and growth edges that I found during my personal reflection. My supervisor was also open to more frequent consultations if I felt I was in need of additional support. In addition to some more general areas of my practice, I reflected on missed opportunities with patients. My supervisor was always very open and honest with me about my skills and practice ability and would often offer her own reflections of my performance. She was transparent in her own actions as well and this again was beneficial to my learning experience. Mirroring this engagement of reflection aided in fostering an increased level of support and comfort within these interactions and with my overall relationship with my supervisor.

Beyond all of these, she was also very open to hearing my perceptions and reflections during these consultation meetings. I felt comfortable exploring with her the revelations I was able to unearth throughout my journaling. My supervisor openly engaged in discussions of power and privilege on the in-patient unit; and was able to enhance my understanding of these from a more informed perspective of the unit's functions. I was able to speak with her about systemic gaps and she was able to reflect back how geriatric care within the hospital has changed over the past few decades.

My supervisor was also able to provide her insight as to my approach to practice. She would share her observations of my skills. I was appreciative of this as it allowed me to have insight as to how I present myself and how others may perceive me. I was urged early on in my practicum to work on my confidence in practice. It was noted that I was capable of the work but that I seemed to be hesitant. I explained that my age as the youngest person on the unit, in conjunction with the fact that I was coming from an academic setting fed into areas of self-doubt. However, I reviewing this observation I worked to problematize my identity as a student on the unit and challenged myself to improve my confidence in practice. I found this to be achievable

again over time and in conjunction with my peer consultation. I was pleasantly surprised to find that many of my peers were having similar issues. It was reassuring to know that these feelings of trepidation were normalized among my peer group. This also aided in building rapport offering a safe foundation of communication amongst my colleagues. In terms of direct practice, once I began to challenge areas of hesitation I was able to engage more freely in reflection in the midst of support. This was a skill that I worked to continue to cultivate during the duration of my time at GBHS. I will go on to discuss my level of reflection following my practicum below.

Through consultation, I also became more comfortable sharing my thoughts and observations within the larger multidisciplinary setting on the unit. Though we may not have always agreed, I felt very comfortable discussing my thoughts and inquiring as to the opinions of others; from nursing, the physician as well as the manager of the unit. I truly found each discipline to be open to having these discussions with me and they were very thoughtful in their input. I feel that much of this accepted engagement was based in my role as a student. I was, regardless, very thankful that so many individuals agreed to partake in these conversations.

Systemic Challenges Witness through Practicum

Critical theory is responsible for the analysis of power within the critical approach to practice, power is seen as not only personal, but also structural (Fook & Gardner, 2007). This in turn prompted me to explore the greater social and political structures at play with a critical lens. As my passion for working with this population has been explored in detail both personally and professionally; I had the opportunity to familiarize myself and interact with many of the overarching structural systems in place for older adult mental health, specifically dementia.

Research suggests that by the year 2038, there will be a new case of dementia every two minutes (Wilson, 2014). If nothing changes by 2031 there will be a projected 1.4 million

Canadians living with dementia (Alzheimer's Society, 2012). With the impending growth of the elder population in Canada, economists have been forced to examine the future constraints on the economy due to expenditures as healthcare costs and additional service for older adults increase (Campbell & Novak, 2010).

Currently Canada is promoting and 'Active Aging' agenda, wherein seniors are highly encouraged to maintain an active and healthy lifestyle as they continue to age (Active Aging Canada, 2016). It is important to note that the terms "successful aging", "aging well", "optimal aging" and "active living" are not synonymous, each of these terms are backed by a separate theoretical framework, and are not to be confused with Active Aging (Paúl, Ribeiro, & Teixeira, 2012). However, each of these frameworks hold the same social underpinnings for elderly, where an assumption is made that each person has the ability to, and therefore should, retain good health as they grow old (Holstein, Parks, & Waymack, 2011). Unfortunately this is not a viable solution for many Canadians, let alone older adults with a dementia diagnosis. Although being active can help to support a healthy lifestyle, there is no guarantee that it will prevent dementia as people age. This philosophy makes the broad assumption that all Canadians have access to the various aspects of life which promote a healthy lifestyle. These include but are not limited to good food, exercise, and positive socialization. What the philosophy does not highlight is that this is not an accurate representation of the social structure of Canada

Direct medical costs represent a small portion of the total cost of dementia care in Canada (Dudgeon, 2010). The bulk of the cost for dementia care is actually shared between informal and social care (Dudgeon, 2010). According to a report published by the Alzheimer's Society in 2011, Canadian's worked 444 million hours of unpaid caregiving to family members with dementia (Alzheimer's Society, 2015). On average, there are two or more family members

providing care; in terms of lost wages, an estimated \$11 billion approximately 228,000 full-time jobs annually (Alzheimer's Society, 2015; Dasko, 2015).

As I was fortunate enough to work on both the in-patient unit as well as with the out-patient team I was able to gain a balanced perspective on older adult care concerns. Paramount among these was the frustrations felt by client, families, and staff alike surrounding the lack of available community resources for clients and their caregivers. With the constant push from the hospital to maintain a high level of patient flow, clients who needed Long-Term Care often had to return home following their assessment to await placement. Here the care responsibilities often fell to family to provide support, as private help was frequently too expensive or not geographically available in such a rural setting. When respite care was available, I witnessed its inconstancies. At times support would show up at the last minute so caregivers did not have time to prepare or when expected, not show up at all. Hours of support offered were minimal and failed to address the daily needs that those living with dementia require. Understandably this caused hardship on the family as well as the older adult themselves. Increased burnout in older adult care can lead to various issues such as elder abuse and neglect which was an area during my practicum I had to be conscious of and assessing for in the community.

There are several opportunities for social work to have an impact of the structural issues surrounding older adult care with and without a dementia diagnosis. I feel that first, there needs to be advocacy at all levels macro (across the healthcare system), mezzo (across local health and social services), and micro (family and immediate community) to increase the accessibility of knowledge surrounding dementia. As at this time there is no known cause for dementia and no cure, it is important to continually engage in research for both pharmacological as well as non-pharmacological interventions. This would provide caregivers with more information about ways

to offer informal support in an effective way. Beyond research, knowledge building among older adults and their caregivers can prompt grass root groups to form which can provide peer support in the absence of formal supports.

It is also imperative that the severity of the impact that dementia is projected to have as the population age is heeded by state supports. Without question there will be an increased need for supportive care in the form of Long-Term Care Homes as well as community supports. Failing to address this issue will impact hospital settings who will be forced to accommodate the overflow of people. Currently the system has developed an infinite loop. People who are unable to thrive in the community are admitted to hospital. There is then a push for increased patient flow from the hospital, so if nothing is severely medically or mentally threatening, the patient is discharged back to the community. There are not enough community supports to adequately respond to the needs of the patient and or their families. In order to address this, older adults present to the hospital; and the loop continues. With increased community supports the hope is that we could reroute the trajectory of this loop.

Including social work as a viable community support is of equal importance to healthcare supports. In addition to providing psychoeducational modalities to clients and families it can work to vet client needs to the appropriate resources. This in turn may also result in decreased hospitalizations and allow the individuals to maintain a more autonomous lifestyle within their own homes and communities as opposed to being placed in a Long-Term Care setting.

Post-Practicum Revelations

Reflecting on where I am following the completion of my practicum at GBHS I have noticed a number of changes in my identity as a practitioner. An unexpected benefit of this topic was the ability to go on journey of self-discovery, which in reflection is not unlike the journeys

that social workers often ask clients to go on. It prompted me to examine my practice and approach in a way that was not simply a regurgitation of a structured theory. Rather, it provided me the opportunity to deconstruct my entire approach to social work practice. This included my knowledge, language, power, and identity in order to see where these beliefs, biases, and responses were founded, and how they impacted me as a person and in turn the work that I do with others.

I was initially timid and unsure of my abilities in practice. This caused me to be hesitant in my direct practice but it also resonated as an underlying need to promote my role as a social work ‘professional’ rather than a practitioner. Working through the situations and experiences I was presented with on the in-patient unit as well as the out-patient team has allowed me to gain confidence in my role as a social worker. Being conscious of self in practice also helps to develop the related skills to process difficult situations faced in the field (Marlowe et al., 2015). I attribute this growth to engaging in critical reflection and consultation with myself, my peers and my supervisor.

Consultation urged me to become more self-aware and to challenge my subjective lens through each interaction I had. It also allowed me a safe space to debrief situations that were difficult. I was able to be open about missed opportunities for support and to unpack my biases in a way that was constructive to my future practice. It was through this that I developed a greater appreciation and understanding for the need of clinical consultation in practice within your own scope. My fellow social workers were able to highlight and challenge me on subtleties of my practice that may have gone unnoticed by someone unfamiliar with social work practice techniques and principles.

The setting of my practicum, though initially daunting, also challenged my practice and forced me to expand my knowledge and use of language. In doing so, I was also able to gain a better understanding of the ways in which power is exercised with the older adult population, and ways that this could be addressed. I became aware of systemic barriers which also negatively impact the power that those living with dementia have. This has caused me to reflect on the continued need for advocacy within this population. In addition to direct practice implications, education, and knowledge sharing surrounding the importance of geriatric social work is still an area for improvement within social work education.

Having social workers engage in critical reflection when working with older adults is not only ethical it is imperative. Working with a population that is not only vastly under supported, is not understood, and that will only continue to grow, the margin for doing harm to these clients is expansive. Social workers have an obligation to do no harm to those they support. Part of this process is in understanding that social work is a vocation of practice; because it can never be perfect. Where initially I was worried about how my challenges in practice may have been interpreted by others, I now hope that they can be seen as an example of the importance of the critically reflective process and contribute to the shift in education surrounding older adults.

Post-Practicum Stage of Reflection

Preceding this exploration of the critical reflection approach to practice, I feel that my process best aligned with Kondrat's (1999) definition of reflection. I was able to explore my actions, thoughts, beliefs, and assumptions, and correlate these various aspects of self to my practice (Kondrat, 1999). Where I had initially believed to be engaging in truly reflective practice, I now see that I was framing my practice skill and ability against feigned objectivity. Participating in consultation with my supervisor and peers and well as journaling for critical self-

reflection has had a profound impact on my identity both personally and professionally. It has also provided me the opportunity to identify the many subjective aspects of my social work practice that I was previously oblivious to.

As my practicum has finished, I believe that I am now more closely aligned with reflexivity. Here, the practitioner is mindful not only of the aforementioned areas found within reflection, but is also aware of discourse/language, power dynamics, and how these are all filtered through the ‘self’ within and outside of practice settings (Marlowe et al., 2015). In addition to the added levels of contextual depth, reflexivity is also distinguished by its timing (Trevelyan, Crath, & Chambon, 2014). Whereas reflection is focussed on examining an experience that has already happened, reflexivity is focused on examining these considerations in the midst of practice (Trevelyan, Crath, & Chambon, 2014; Fook, 2012; Lam, Wong, & Leung, 2007; Yorke, Grant, & Csiernik, 2016). Although, I do not feel I have reached the level of critical reflection that can be acquired through praxis or having a ‘third eye’ (Yorke et al., 2016), with time and continued effort in engaging in active critical reflection, I hope to achieve this one day. Given the contextual nature of reflectivity, critically reflective practice becomes an ongoing process that requires constant revision, reflection, and action. As such, this is an area of practice that I will continue to pursue.

Summary

In summary, I was able to witness a shift in my practice skills and abilities throughout the course of this practicum. Engaging in a critically reflective approach to my own social work practice has helped me to grow exponentially as a practitioner in terms of confidence. Through my clinical consultations with myself, my supervisor and my peers I have developed a new appreciation for the role that a more in-depth form of reflection. Through this confidence I feel

more comfortable in fostering conversations about the issues older adults are facing due to a fragmented system, especially within my own rural Ontario setting. Through this experience I feel that as I continue on my practice journey, that I continue to enhance my self-awareness. It is because of this, and the myriad of experiences I was fortunate enough to have during my time at Grey Bruce Health Services, that my practice will only continue to improve and strengthen. In my final chapter of this document, I will explore the ethical considerations attached to my practicum as well as highlight several aspects which will have implications for my future social work practice.

Chapter 5: Conclusion

Overview

In accordance with the prerequisites of the MSW program at Laurentian University, I have completed an advanced practicum totalling 450 hours (Sylvestre & Coholic, 2010). This practicum was completed at Grey Bruce Health Services hospital in Owen Sound, Ontario. My practice experience there was shared between the in-patient Psychogeriatric Unit and with the out-patient Geriatric Behaviour Response Team. The goals of engaging in an advanced practicum were to both gain and enhance skills within my own social work practice with older adults and review these in turn, with a critically reflective lens. In this final section of this advanced practicum project I will discuss ethical considerations that were observed throughout the course of my practicum. Lastly, I will review the key aspects of my practicum experience and how these in turn, have impacted my social work practice going forward.

Ethical Considerations

Throughout the course of my practicum with GBHS working with a marginalized and vulnerable population within small communities, there were several ethical concerns to consider. In anticipation of this, I explored broad areas to consider, and in turn developed plans for responding to these issues. According to Creswell (2014), one of the ethical issues that can arise prior to engaging with clients pertains to gaining permission from the agency and ensuring that the topic being explored will meet the needs of the clients. Although my practicum was not a formal research study, during it I worked with a population that will continue to increase in number as the transition of the baby-boomer generation into older age becomes complete (Ministry of Industry, 2011). Through theoretically driven interventions, my practical knowledge, experience, and critical reflection, I was sure to closely follow the current version of

the OCSWSSW Code of Ethics and Standards of Practice (2008, 2nd edition) as I served the clients associated with GBHS. The topic of critical reflection, though not specific to the older adult demographic, is a practice framework that can be used in social work practice settings. The goal of critically reflective practice is to insure that the social worker is continuously reviewing, challenging, and addressing their subjective approach to practice; the outcome is that the practitioner engages in a more ethical sound manner. I was clear with my supervisor about my intent for engaging in critical self-, and supported reflection within this practicum, thus addressing the initial ethical concern of field research by Creswell (2014).

Another ethical issue that I remained cognisant of was preserving the privacy and anonymity of the clients with which I had the privilege of working (Creswell, 2014). This was a significant concern due to the size of the rural communities that the practicum took place in. To circumvent any issues with regards to this, I read and signed an agreement of compliance with GBHS's confidentiality and privacy policy. Additionally, the OCSWSSW Code (2008) outlines the limited circumstances in which the confidentiality agreement between practitioner and client does not apply (e.g. risk of suicide, abuse of vulnerable people, etc.) which I was clear in explaining to clients and their supporters alike. I reviewed and referred to the OCSWSSW Privacy Tool Kit (2005), which provided me with an in-depth explanation of the Personal Health Information Protection Act (2004) and its respective adherences. When documenting, I was sure to use a range of measures to promote client anonymity and confidentiality including but not limited to medication record number identifiers, or at times simply age and gender. As well, once I was finished uploading any documentation to the client's electronic health chart I would dispose of all physical notes into confidential shredding. Engaging in on-going check-ins for consent with either the individual or any substitute decision makers with power of attorney was imperative

when gathering and/or disclosing information and I was sure to have completed this process prior exchanging collateral information.

As with all clinical relationships, it is important to be cognisant of the inherent power imbalances between practitioner and client (Creswell, 2014). I addressed this risk by reflecting on my personal and professional process through daily reflective journal entries, as well as meeting regularly with my supervisor to consult on the various intervention modalities used within the practicum settings. If there were any circumstances that arose which could have infringed on ethical social work practice I was clear in communicating and addressing these to my supervisor or other medical staff members. Engaging in the overall process of the critical reflection approach caused me to problematize my own skills and practice and examine various occurrences through various ethical lenses. It was in response to these ethical concerns that I felt pursuing a practicum based in critical reflection, would best address these issues and have a lasting impact on my practice.

Implications for Future Social Work Practice

As demonstrated earlier in this document, there has been an increase of interest in recent social work literature exploring the role of critically reflective practice and the use of self (Fook, 2012; Fook & Askeland, 2007; Fook & Gardener, 2007; Marlowe et al., 2014; Fisher, 2003; Trevelyan, Crath, & Chambon, 2014; Kondrat, 1999). Critical reflection, reflexivity, and praxis have emerged as important topics in contemporary social work literature. Although each discourse has historical connotations, the evolution of these practices in a post-modern era has opened discussion for current and future social work practitioners. Webb (2000) asserted that without critical thought and critically reflective practice, one cannot engage in “good” social work practice. In kind, my practicum experience at GBHS with both the in-patient

psychogeriatric unit as well as the BSO out-patient team provided me with opportunities to engage in critically reflective practice and complete my myriad of learning objectives through clinical case management and assessment. I was able to shadow and work alongside various disciplines such as: doctors, nurses, and occupational therapists which provided me with a greater understanding of context to review through a critical lens. I gained valuable knowledge and social work skills through both my front line work and my clinical consultations with my supervisor. I also engaged in consultation with other social workers within GBHS as well as my MSW colleagues. Having the opportunity to engage with clients both in hospital and in the community provided me with a well-rounded experience of older adult mental health supports. It highlighted for me the struggles of providing this support in a rural setting and within a fragmented system. Three key areas of my practicum which have had a profound impact on my practice of critical reflection include working with multidisciplinary teams, case management, and clinical consultation.

Working within a Multidisciplinary Team

Having the opportunity to be surrounded by a variety of perspectives of care offered me more opportunity to explore my own practice milieu than I thought possible when beginning this journey. Gerontology is described by Alkema and Alley (2006) as a unique discipline within which theories of aging are conceptualized from an interdisciplinary perspective. Due to the current social trend of wholistic care, there has also been a strong shift to incorporate social work as a part of a multidisciplinary team (needs a citation). Loucks-Campbell (2011) notes that this is especially true within medical settings, as social work's addition offers the client the opportunity to receive non-medical support in addition to medical intervention (Turner, 2011). As a result of

this exposure and inclusion, I was fortunate to have experiences that have influenced my future social work practice.

Language

Within a critically reflective approach to practice, it is important to remember that “language is not neutral” (Fook, 2012 p.75). It is with this in mind that as a social worker I must take into consideration the subjective or dominant views, which, as Mandell (2007) asserts can develop or perpetuate ideologies. With the backdrop of a critically reflective approach to practice I was able to interpret nuances of language with a greater appreciation; in both the language that was used by others but also in the language I was using. Within a hospital setting, there truly is an entire vernacular to learn, which took me some time to fully understand. Over time I was able to communicate effectively in this language and recognize the power imbalances that the label-based or binary course of language often holds, particularly within a medical setting. I realize that in reflecting on the terms used by others such as “elderly”, “demented”, “medication non-compliant” I was able to challenge this and reframe it to be inclusive of the person as opposed to the identifier (older adult, person living with dementia, prefers medications crushed). I quickly appreciated that in order to effectively engage with the members of the multi-disciplinary medical team that the knowledge and use of ‘their’ language is key. Similarly, in order to aid the client’s/patient’s families in understanding at times I had to act as a translator between the healthcare rhetoric of team members and more common speech. I realized how the use of language became a pillar of my social work practice in terms of communicating empowerment, and strengths. By insuring that I am able to clearly communicate within the multidisciplinary team, I worked to support the holistic approach to geriatric care. Often times when working with the older adult population care needs are increasingly complex and therefore require a more

comprehensive approach to care, medically and non-medically. As such, it is important for social workers to be able to communicate with other disciplines when serving clients. In addition to opportunities to coordinate care, it also allows for more transparency in the care of the client among staff and family supports. I have found this shift in language awareness transcends my social work practice and extends into my personal life as well. This has caused me to be more cognizant of how I speak to clients, formal and informal supports, as well as colleagues.

Systemic Constraints and the Role of Social Work in Multidisciplinary Teams

Working within a multidisciplinary team has also afforded me the opportunity to critically appraise the systemic barriers that are experienced throughout various levels of geriatric mental health. Although my background in social work education is in a structural approach; it was in seeing the impact that the systemic constraints had on the front line members of staff that resonated with me. Trying to navigate a fractured geriatric care system is difficult. Often times various issues such as pressures for a faster flow of patients through the hospital unit, to inadequate home supports, left the members of the in and out-patient teams distressed, while feeling powerless to address it. Though I found staff to be doing their best to attend to these issues, they were also placed in the difficult situation of maintaining the status quo in order to meet capricious objectives, attending to the responsive behaviours of patients on the unit, often while understaffed. I found that so much time was spent addressing these immediate concerns, that a deeper and more macro discussion was not taking place. It was through my discussions with my placement supervisor that I was able to gain a better understanding of how things had been for geriatric patients and staff, specifically social workers in the past within this setting. Experiencing these frustrations, prompted an understanding of the ways in which care had been provided historically at GBHS as well as how it is currently being addressed

internationally and in some cases with greater success. In light of this, I feel encouraged to continue to advocate for change within the various contexts of geriatric mental health care.

Part of this continuing path includes keeping abreast of contemporary social and political issues as they relate to older adults beyond mental health; but it is also taking that awareness and sharing it with others. Ben Carniol (2010) explains that social justice is a continuous process that is more than addressing injustice, but about the construction of equitable personal, social, and political realities based on principles of compassion and equality. In my past I have been able to engage in various forms of advocacy; working from both within and outside of greater social and political systems alongside others to demand sustainable and just change. Though I have never addressed the healthcare system in its entirety, I feel encouraged to continue to engage in acts of advocacy within multidisciplinary teams for a multidimensional approach to change. My hope is that with inclusion of various relevant supports that a greater disciplinary discourse surrounding geriatric care will have a positive impact on the future of care and geriatric social work alike. It is in consideration of this that I feel there is a strong need to have social work included in multidisciplinary teams, particularly in regards to the structural constraints of geriatric care. With the current ministerial pressure of shortened stays in hospital, the role of social work is seen as an asset to both the client and healthcare staff. Social workers have a duty to engage in advocacy. This can help to foster conversations at more mezzo and macro levels and work toward engaging various members of the geriatric care community to also push for a sustainable change with a greater focus on the person as opposed to the politics.

As I have mentioned, during my practicum I was pleased to see the role of the social worker included as a valued team member, able to provide input and offer suggestions that were considered respectfully amongst various members of the team. Although it was ultimately the

physician's decision in terms of patient care directives, it was reassuring to see that the physician was open and interested in gaining the feedback from the social worker about external issues which may be impacting the client's mental health or behaviours. In the past, I have been a part of interdisciplinary geriatric care teams wherein each 'professional' was very linear and territorial over their area of practice. The resulted in team members often refusing to engage with other disciplines and negating the possibility for a holistic care approach. I have seen how this can contribute to a toxic working environment; it transfers into the quality of care that can be offered to clients by the team. Social workers are an integral part of the multidisciplinary team when exploring geriatric care as they are able to make valuable connections to resources in the community for clients and their families; they operate from a widened scope of practice that extends beyond the medical field. This expansive scope includes peer, legal, social, and at times financial support opportunities. Social workers are able to provide clients and their supports with resources and access to broader community provisions which can offer a more comprehensive continuum of care once the client is discharged from hospital services. With this, the hope is that it will reduce recurring presentations in the healthcare setting if their needs are able to be met in the community and would in turn aid in some of the more pressing political issues multidisciplinary teams are currently face.

Case Management

Another area of my practicum experience that I feel has profound implications on my future social work practice is in the area of case management, specifically with older adults. Through case management, social workers are able to support vulnerable individuals within a fragmented system of human service organizations, in an effort to ensure that all individuals receive the support needed (Rothman, 2002). During my practicum, I had the opportunity to

engage in Organization-Based Case Management, which is a single point of access for client support which encompasses intake, assessment, care-plan development and transitional support (Woodside & McClam, 2006). Austin and McClelland (2002) note that in addition to social work practice, case management is an integral aspect of older adult community care. The result of a fragmented system, case management provides social workers with the ability to aid their clients in system navigation (Bogo, 2006). Both of my practicum settings enabled me to utilize a variety of skills with clients as well as informal and formal supports alike, which have enhanced my personal knowledge, ability, and level of comfort in case management. With the aging of Canada's population, in my opinion, having an understanding of effective assessment skills that are specific to older adults will become a necessary part of social work practice, regardless of the demographic you are supporting.

Older Adult Assessment Skills

In terms of assessing clients, the aforementioned P.I.E.C.E.S. (Hamilton et al., 2010) format provided me with a comprehensive structure of assessing potential causes for older adult client behaviours. I felt this to be a beneficial assessment framework as its design was holistic in nature, exploring a client's life including physical, intellectual, emotional, capabilities, environmental, and social aspects (Hamilton et al., 2010). As a social worker who was new to assessing clients, specifically older adult clients, I found this formula to be profoundly helpful. It prompted me as a social worker to make sure I was exploring all areas of this client's life and how they in turn could be impacting their presentation. Additionally, it was a format that was very clear, concise and easy for other professions to follow (i.e. nursing). This helped to foster conversations surrounding the client's assessment in a way that was relatable to the other members of the client's care team. I felt it was also important that it was an aspect of case

management that a client's family could also participate in; this became especially important as individuals progressed in their disease.

In terms of greater social work practice, I also feel that P.I.E.C.E.S. (Hamilton et al., 2010) is a tool that all social workers who are working with older adults should be utilizing; regardless if they are diagnosed with dementia or not. I came to find that issues of behaviour or even mental health can become intrinsically linked with physical ailments within the older adult population. For social workers who are not familiar with a more medical social work knowledge base, it can be a great way to begin having these conversations with clients. The resulting information can help to provide social workers with some direction as to various non-pharmacological strategies that may be constructive for clients to trial such as mindfulness, music or art therapy. It can also provide some insight as to various community or tertiary services or supports that the client or family may find helpful from grassroots support groups, to community activities such as car shows, or respite programming. Social workers are prompted to engage in a thorough assessment while building rapport with the older adults by discussing various aspects of their life of importance. As this is not a complicated structure to follow, it is also accessible for any social worker to use as a part of their practice.

Clinical Consultation

Often in social work the term supervision is used to describe the meeting and discussing of performance or concerns within practice between a supervisor and practicum student. I have chosen to use the term consultation instead of supervision as it seeks to equalize the power imbalance within the supervisor/worker relationship. Engaging in clinical consultation was perhaps the most impactful, and influential aspect of my practicum. Failing to problematize social work practice promotes an unattainable culture of objective assessment, silence, and

individualism, wherein the dichotomy of “correct” or “incorrect” practice is perpetuated. This in turn places pressure on the practitioner to avoid being “wrong”. It is argued that these feelings of uncertainty and anxiety are necessary experiences for critical practitioners who wish to engage in truly ethical practice (Trevelyan et al., 2014). Consultation within the critical approach helps to transform practice to encompass more empowering, ethical, and effective experiences for both the practitioner and the clients. This is done by allowing the practitioner a safe space to debrief events related to and surrounding practice (Marlowe et al., 2015). As mentioned, I have never had the opportunity to have consultation in my practice with a social worker before. I am grateful for the opportunities I have had through my previous work experience to receive consultation opportunities with professions outside of social work. However, throughout the course of this practicum I quickly came to realize the benefit of being able to engage in critical consultation with colleagues and peers that were able to have more in-depth discussions about social work practice; its ethics, theories, applications, and practitioner challenges.

Importance of Social Location

A benefit of engaging in clinical consultation with my supervisor and peers was the ability to have discussions about social work practice challenges. Included in these were discussions of power, which I have reflected in earlier chapters, as well as social location. This is another area for constant reflection as I continue on my social work journey. In relation to my practice it is imperative to remember that at this time, I am a young, able-bodied adult, cisgender female, from a small rural town located in Grey County. Here, there is a dominantly white, lower-middle caste system. I am Caucasian, heterosexual, and completing the academic requirements for a graduate degree from Laurentian University.

It is important that I reflect on the ways in which I am currently privileged in my social location including my youth, race, sexual orientation, physical abilities, academic standing as well as being cisgender. It is also important to reflect on the ways in which I am disadvantaged including being a young, female, and living in a lower-middle caste system. As demonstrated above, I have many areas of my social location that hold power within my practice, and must remain cognisant of these when supporting clients whose social location may not provide areas of pre-structured power. Conversely, it is important to be able to recognize the power that the social location of others supports in a client's life hold and how these too effect their relationship with the client. Having this awareness aids in reflexive practice with both colleagues and clients.

Journaling

Throughout the course of my practicum I had decided to keep a daily journal of my practice experiences and review them on a weekly basis to identify any themes in my thoughts/actions/perceptions that week. In doing this, I was also able to identify various areas of growth within my own practice and could then work to change them. In keeping with the critical lens, I would also be sure to evaluate my personal feelings of my work week and try to look at various aspects of my personal life that could also be influencing these. By keeping a detailed journal of my experience and practice skills I was able to identify areas within my practicum which I found to be frustrating. This helped me to reframe feelings of having to be 'perfect' in my social work practice. I began to see where areas of my personal life bled into my practice. Although this was not done negatively or with ill intent, it was just something that I began to become more and more conscious of as I continued in my practicum. Through journaling I felt that I began to respond to clients and families with a greater confidence; I became more familiar with the system but also as I became more familiar with myself. Being conscious of self in

practice also helps to develop the related skills to process difficult situations faced in the field (Marlowe et al., 2015).

When beginning this experience, I was not convinced that journaling would provide me with as many opportunities for reflection and consultation as it did. When I began, I found it to be an arbitrary exercise, one more task for me to complete at the end of a work day. But I soon came to realize that it was, in many ways, a great way to engage in self-care as well as critical reflection. By first externalizing my experience and perceptions of my practice, and then inviting the opinions and viewpoints of others, I was able to foster some amazing conversations and reflections opportunities. Where I initially did not think that journaling was an exercise that I found necessary, I now consider an essential aspect of my social work practice. Engaging in journaling for me has helped me to have difficult conversations with peers and colleagues. It has allowed me to approach my own social work practice with more empathy and compassion than I had in the past.

Though it is not for me to claim journaling is an effective method for all social workers to engage in, I feel that the continued implications for including journaling in my future practice are beneficial. For those who are contemplating incorporating aspects of critical reflection into their practice, especially if you are just starting out, journaling can be a great tool to utilize. Engaging in critical reflection can help to foster more ethically sound social work practice and journaling provides both an outlet and a reference for reviewing practice. I found this process to be advantageous as a modelling tool to consider in use with clients who are looking to have more insight to their thoughts/actions as well. This can foster rapport and can lead to empathetic, transparent conversations within the therapeutic relationship in terms of self-perception.

Clinical Consultations with Supervisor and Peers

While engaging in practice on the in-patient unit I was able to meet bi-weekly with my supervisor to explore my practice skills. Often times there is an intense sense of anxiety, fear, and embarrassment surrounding the self-disclosure, of mistakes or growth opportunities for fear of reprimand. Within these contexts the format of asking critical reflection questions can cause the practitioner to feel vulnerable, especially if critically debriefing with peers (Fook & Askeland, 2007). Conversely, I felt comfortable disclosing concerns I had about my own practice and gathering feedback from my supervisor. She was very proactive in ensuring that I was able to work towards and through the goals and growth edges that I found during my personal reflection. Through my practicum I have strengthened my resolve that critical consultation fosters the best transformative feedback. It opened up a dialogue surrounding my direct practice between other staff, my peers, as well as myself that I had not had the opportunity to engage in to this degree previously.

It was soon after beginning my practicum that I came to realize that I was in a gifted position as a student. I relished the opportunity to gain feedback from many different sources and to be able to try approaches or techniques in an environment that was supportive and fostered moments for mentoring. If I had the opportunity for training that would enhance my skills, I took it. The prominent benefit of engaging in clinical consultation is to build a sense of comradery and understanding amongst colleagues. Though this is not the end goal of consultation, I found that it did help to quell uncertainties and anxieties that I held about my practice. I was able to find commonalities amongst my peer group in some of the challenges I was facing. Having this sense of belonging is important within any work culture, but particularly important in the helping profession. It is important to feel support; that others are hearing your concerns and that you are

not alone in some of the challenges being faced. Miehl and Moffatt (2000) argue that it is in this anxiety that practitioners are best able to relate to the 'other' and develop their identity as a practitioner through various imaginative possibilities.

Engaging in clinical consultation can hold many benefits for a social work practitioner. In my experience it helped to develop rapport among my colleagues through open and transparent dialogue. Clinical consultation can mirror a positive representation of the therapeutic relationship for the social worker while challenging them to engage in multiple levels of reflection simultaneously. The benefit to this is to push the social worker toward a more reflexive or praxis approach to practice. Through the debriefing process, social workers are able to highlight areas of frustration or concern they have. This has the potential to reduce burnout over time, as increased awareness of self can help to avoid negative traits from becoming repetitive and impacting practice. Although there are benefits to viewing approaches from alternative lenses it is just as, if not more important, to be able to reflect amongst peers or with a supervisor within the same field. This offers a more focussed approach to posing critically reflective questions, and also allows for information sharing amongst colleagues. Within GBHS the in-patient social workers organized grass-root monthly meetings to discuss various issues and offer peer support and consultation, as many of the social workers have managers who have a nursing background.

Having experienced the new level of engagement that can come from having routine clinical consultation, I plan to incorporate this as a permanent aspect of my practice. Taking my cue from the social workers at GBHS, should I not be able to engage in clinical consultation within my work environment I will seek to form opportunities through grass-root opportunities or external social work practitioners.

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